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Separation and the
What Goals for
New Hope for
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A preschool child tries out the nursery school piano keys. A child's natural curiosity, when stimulated by the environment and encouraged by the adults in his life, is an important factor in the development of the intellect, as is pointed out in the article beginning on page 8.

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In recent years, the development of special nursery schools and day care centers for mentally retarded children has spread throughout the country. When children are enrolled in such schools and centers at the chronological age of 3 or 4, in mental age they are often well below 3 years, usually the lowest age of admission to nursery schools for children of normal intelligence. This fact faces administrators and teachers with important questions not only about what modifications in the traditional preschool program are necessary but also about what differences in adjustment and emotional reaction can be expected between mentally retarded and normal 3- and 4-year-old children.

Nursery school educators have long stressed the importance of giving the child a chance to enter the school gradually, usually in the company of his mother. However, nursery schools for retarded children, including those that are highly rated, often start right off by transporting the children from home to school, paying little or no attention to the possible emotional effects of separating them so suddenly from their parents.

In pointing out this discrepancy, we are not opposing nursery schools or day care centers for retarded children, which we regard as necessary, but we are suggesting that such programs need to examine their ways of operating. Again, in focusing attention on separation reactions in young children, we are not suggesting that such reactions are undesirable—quite the contrary, for it is part of normal emotional development for a child to react to separation from his parents by protesting. We are maintaining that retarded children may need special help in expressing their emotional reactions and adjusting to separation as steps toward developing a sense of autonomy and identity.

Specialized nursery schools and day care centers provide desperately needed relief for parents, especially for parents of moderately and severely retarded children. If one waited for the mental age of 3, the moderately retarded child would be at least 6 years old before admission. From the standpoint of the child's needs, a stretched-out period of complete dependency on confused and emotionally ambivalent parents can produce unnecessary infantilism. The retarded child may well need the stimulation of an objective outsider to develop his potentials.

We are concerned here with the psychological problems of mildly retarded children, who presumably have the same needs as other children for healthy emotional development. In the past, mildly retarded

SEPARATION REACTIONS

in young, mildly retarded children

JANE W. KESSLER • GRIDTH ABLON • EDITH SMITH

children were rarely diagnosed until they reached school age, but today specialized clinics using refined diagnostic methods are locating more of them in their earlier years.[1] Early diagnosis is generally assumed to be advantageous to the child, but this is true only if it is followed by a therapeutic program. By and large, because of the child's intellectual deficit, the recommended therapy is special education. However, identification of a mental deficit should not blind us to the overall needs of the child.

Many people today are questioning whether the practice of enrolling children of normal intelligence in nursery school at the age of 3 is based on sound child development theory or whether it is simply a matter of tradition. However, the rationale underlying this convention is worth examining. Anna Freud,[2] in a psychological exposition of the desirable prerequisites for nursery school entry, has described a child's readiness for a nursery school experience in terms of the child's status along certain lines of development. On the line toward bodily independence, she suggests that the child should have reached the stage where he can enjoy the kind of food or drink given in nursery school and is able to use the school toilet.

On the line from egocentricity to companionship, Miss Freud suggests that the child should be able to relate to other children as helpmates in carrying out a desired task, such as playing, building, or destroying. Thus, although the normal 3-year-old is selfishly motivated, he responds to what he sees other children doing and is able to engage in some cooperative play. He is at the beginning of the stage when "play material serves ego activities and the fantasies underlying them" [2] and is well beyond the stage when all objects are handled in the same way—everything is an object to mouth, twirl, or throw.

Anna Freud does not discuss language development as such. The nursery school teacher, however, expects a child to be able to express his wants in words and to comprehend simple verbal directions and explanations. The child who is ready for nursery school can understand the words "going to school" and "going back home." Part of the time, at least, he recognizes that separation from his mother is temporary and he knows what to expect when she leaves. However, the normal 3-year-old has a shaky sense of time that is more dependent on his feelings than on the clock.

The child's status on the developmental line from total dependency to self-reliance is crucial in determining the nature of his reactions to separation. Anna Freud maintains that ideally the child entering nursery school should have reached the stage of "object constancy," at which the absence of the external object—in this case, the mother—is replaced by a remembered image that remains stable regardless of the child's feelings. At this stage, the child knows that his mother exists independently of his im-

Based on a paper presented at the 1968 annual meeting of the American Orthopsychiatric Association.

Jane W. Kessler, right, is professor of psychology and director of the Mental Development Center at Case Western Reserve University, Cleveland. Both of her coauthors, **Gridth Ablon**, psychologist, and **Edith Smith**, social worker, received their professional degrees from Case Western Reserve. Dr. Ablon, who interned at the Center in 1967, is now teaching at the Newton College of the Sacred Heart. Mrs. Smith has been on the staff of the Center since 1964.

mediate perception and that she will reappear no matter how frustrated or angry he may feel at the moment. When the child appreciates his mother's independent and constant existence, he recognizes his own identity and autonomy. This enables him to retain his self-control in his mother's absence. This sense of "I am I wherever I may be" follows the awareness of differences between "me" and "you."

Such individuation first appears in the child in the form of learning the boundaries and powers of his own body. This is followed by a process of learning to know his own mind. Gradually the child corrects his first assumption that as he thinks, perceives, and feels, so does the rest of the world. Discovery of such differences helps him to become aware of himself as a distinct person and to imagine others going about their everyday affairs even when he is not an eyewitness. When a child has reached this point, separation from his mother does not signify permanent loss to him.

Nursery school teachers expect the normal 3-year-old who has reached the stages of readiness described by Anna Freud to show some separation reaction at the beginning of school. It would indeed be surprising if such a young child had no reaction to finding himself alone in a strange place with strange people. Any adult who has been suddenly transported to a foreign country can understand such feelings. People are sympathetic to the phenomenon of "culture shock" in adults, but surprisingly obtuse in recognizing the feelings that separation brings to a young child. To quote Anna Freud:

> **In the not-too-distant past it was assumed that a child who had reached the age of 3 years 6 months should be able to separate from his mother on the first day of entry at the outer door of the nursery school building and should adapt to the new physical surroundings, the new teachers, and the new playmates all in one morning. A blind eye was turned toward the distress of the new entrants; their crying for their mothers, their initial lack of participation and cooperation were considered of little significance.**

Possibly, the teacher becomes somewhat obtuse so that she will not feel guilty for making the child unhappy. Sometimes the child entering nursery school shows no sign of sadness; he may appear excited or overjoyed. In a detailed case report, Janis[3] describes the initial euphoria and later separation distress of a normal 2-year-old girl starting nursery school. Janis interpreted the child's euphoria as a denial defense that temporarily enabled her to ward off separation anxiety. Anna Freud, in discussing similar observations, suggested that the delay in reacting to separation was due to the young child's slow intellectual grasp of the situation.

But how do retarded children react to separation from their mothers? In view of their slower intellectual grasp, do they experience separation anxiety in greater or lesser degree than 3-year-old children of normal intelligence? Do they show such anxiety in different ways and at different times? A study made by one of the authors of this article, Gridth Ablon, at Case Western Reserve University sheds some light on these questions.[4]

Retarded children's reactions

The experimenter compared two groups of 18 children each with mental ages from 19 to 32 months who had not attended nursery school. Children in one group were mildly retarded with IQ scores ranging from 58 to 83 and chronological ages from 27 to 49 months. Children in the other group were of average intelligence with IQ scores ranging from 91 to 117 and chronological ages from 18 to 32 months. Each child was observed individually for four 15-minute play sessions. In the first and third sessions, the mother was present, in the second and fourth she was not. Various measures were made of the "levels of play" that the children demonstrated in the four sessions. Interestingly, both groups played at the same level when their mothers were present. Separation from the mother led children in *both* groups to regress in level of play and to become much more rigid.

The study revealed a difference in verbalization between children in the two groups when the mothers were absent, although it was not designed to investigate this difference systematically. When the mothers were present, the children's verbal responses were mainly short direct questions—for example, "what is that?"—and many children in both groups were silent. However, when their mothers were absent, normal children seemed to be able to use words

constructively to help master their anxiety. For example, several children asked "where is my mother?" or "will my mother wait for me?" Others asked the experimenter the kind of questions they had previously asked their mothers. In contrast, the retarded children appeared nearly overwhelmed by anxiety. Many of them cried and were unable to talk. While both groups of children appeared to feel threatened by the absence of their mothers, the children with average intelligence seemed to have mechanisms for coping with the problem, but the retarded children did not.

Ablon's observations may explain why teachers of retarded nursery school children have little to say about separation anxiety. Because such children do not give the usual verbal clues to their feelings, teachers often attribute the regressed behavior to the mental retardation itself, and the children's aimless running around to hyperactivity.

Play groups

These observations have led the Mental Development Center at Case Western Reserve University to establish play groups for retarded children as a transitional step to nursery school. The children enrolled are from 3 to 5 years in chronological age and from 1½ to 2½ years in mental age. Diagnostically, the mental retardation represented a variety of organic, cultural, and unknown causes. However, we did not include any children with Down's syndrome in our play groups, because these children seem to socialize relatively well in normal nursery school and a variety of other situations and we did not think they needed this special program.

Groups of seven or eight children meet three times a week for an hour and a half. In the early weeks, the mothers remain in the play room, later they move to an upstairs waiting room, and after several months they leave the building altogether. When the reasons for this gradual separation were explained to the mothers, they said such a plan was not needed because their children would not miss them and would probably not even be aware that they were gone. A few mothers wanted to make a "clean break" because they feared that their children would cling to them indefinitely.

At first, almost all of the children became engrossed in exploring the toys and physical surroundings and paid little attention to their mothers or the teachers. As one teacher put it, they seemed to "float over the surface of the school," showing only brief attention to certain manipulative aspects of the play materials and having little contact with the adults or with one another. Their interest in any toy or activity was short-lived and they soon became excited into a frenzy of giggling, screaming, and aimless running about. However, as the children became more familiar with their surroundings, they sought out their mothers more frequently, particularly when frustrated or upset. For instance, if a child became angry with the teacher, he might run to his mother for comfort or to vent his rage on her. There were, of course, many individual differences. For example:

Mark was an early clinger. He began his struggle between mastery and dependence by standing helplessly in the hall, unable either to go to his mother in the next room or to return alone to the playroom. When he was reassured that it was all right for his mother to stay with him if he wished, he accompanied her back to the playroom. But once there, he ignored her completely. After the teacher worked with him for 4 weeks, showing him pictures of his mother going upstairs and teaching him to say "Mommy stay" and then "Mommy upstairs," Mark was able to manage on his own.

Larry, on the other hand, initially showed no clinging behavior. Larry was the most immature child in the play group when he entered at a chronological age of 45 months and a mental age of 20 months, with an IQ of 45. His language was limited to a half-dozen single words and his activity consisted of running around, shadowing, and mimicking some other child who temporarily caught his attention. He seemed oblivious to his mother most of the time, but panicked if he could not spot her at the moment he felt he needed her.

In the play group, Larry developed more independent actions, more eye contact, and some ability to communicate simple ideas. He even asked another child, "Want a spoon?" He examined himself in the mirror almost every session. It was instructive to watch Larry's sense of identity develop along with his use of language and his ability to tolerate separation. Toward the end of the school year, he would still get anxious after he had been absent for any reason and would need his mother's presence in the playroom.

A disguised form of separation reaction was shown by two other children—resistance to leaving the school at the close of play group sessions. Although such a show of reluctance might have been interpreted as a genuine preference for the school over the home and a rejection of the mothers, the teachers were suspicious because of the children's general air of anxiety. They seemed to be teasing their mothers by defiantly demonstrating, "I don't care anything about you." Their behavior suggested a reversal of roles: they felt they were doing to their mothers what their mothers had done to them. These children seemed afraid of any change in or out of

the play groups. They were the only children who needed their mothers to come back to the playroom when the other mothers moved upstairs. Other children sought mastery of the situation by assuming an active role at the beginning of separation, that is, leaving their mothers at the new place instead of letting their mothers leave them.

Throughout the year, a social worker met with the mothers three times a week while the children were in the play groups.

The objectives of these sessions were to help the mothers (1) recognize and deal with the child's feelings, (2) learn about their own feelings and how they might be communicated to the retarded child, and (3) learn practical techniques of management and home teaching. Often the mothers were surprised to realize the strength of their child's attachment to them—a realization that seemed to open up new doors to those mothers who had felt that their own child had little use for them. Whether these mothers had originally rejected their children was beside the point; the social worker was concerned only with establishing or reestablishing bonds of communication and caring. As a mother became aware of her child's unspoken feelings and their effect on his behavior, she became better able to help the child identify his emotions and to give him names for "sadness," "anger," "loving," "excited," "scared," and so on. She learned the value of talking to the child, explaining things to him, and preparing him for events to come—even when the child did not ask any questions.

The mothers observed how the play group staff related to, worked with, and really enjoyed the children, accepting them as worthwhile, teachable persons with the same kind of feelings and defenses as everyone else. The group structure was also a great advantage to the mothers who gave support and help to one another. They often found it easier to recognize in someone else their own reactions of depression, guilt, and discouragement in having a retarded child. On the other hand, the mothers could convince one another that each had a vital role in making her child happier and more effective. The mothers developed strong ties to each other and were reluctant to leave the group at the end of the year.

Retarded children progress from solitary to parallel play as will this child who sits alone in a corner of the nursery school.

Role of the teacher

We provided one teacher for every three children, since the children did not really represent a group. The teachers saw their roles in working with children who are not ready for the usual nursery school program as a challenge, not as mere babysitting. In organizing the teaching procedures, they looked at separation from a theoretical point of view to determine the ingredients a child needed for mastery. They realized the child needed to become aware of himself as distinct from his mother and able to maintain a constant image of her existence independent of his needs and their fulfillment; and that he needed to see the teacher as distinct from his mother, yet sharing the characteristic of being a safe, protective adult who could also help fulfill his needs.

The teachers made special efforts to identify the child to himself and the other children by showing him his own photograph, saying his name, and verbally calling attention to what he was doing: "Mark is digging." "Mary Beth is hiding." Staff members drew pictures of each child and his mother. At first the children ignored the pictures, but they gradually gave verbal responses such as "Mommy" or "I know it." When the mothers moved to the back of the room, the teachers encouraged each child to show his mother something. In a few cases, the child had to hold a teacher's hand to walk across the room. During the last phase of the separation, the teachers worked to help the children form a concrete image of where their mothers really were and to use words to express their sadness and anger. The teachers felt that the interpretation reached the child if he listened to them or looked at the picture. Several children changed their behavior—tangible proof that the teacher's communication was successful.

As the children separated from their mothers, they turned more to the teachers for comfort and aid. The teachers were able to use their new relationships to help each child socialize with other children.

When the children first enrolled in a play group, they had little ability or desire to relate to each other

as helpmates. Even the several children who had learned superficial manners did not form constructive relationships. They treated peers and teachers as inanimate objects in their environment. They scattered throughout the room, showing little curiosity about each other and ignoring remarks that were not made directly to them. When another child infringed on their play area, they responded either by withdrawal, overactivity, or vocalized complaints directed to no one in particular. If they bumped together, the children often struggled over possessions and needed a teacher's mediation. While mediating, the teacher supplied similar objects or equal divisions that would yield some parallel play. She also suggested verbalizations like "help me," "no, that's mine," or "stop it."

When playing with one child, the teacher always looked for a way to include another nearby child and thus build parallel play into something more social. However, the teacher usually had to provide suggestions. "Mary Beth, Denise is calling you on the phone." "Jon's the daddy; he needs some coffee." "You and Larry go get dishes for the table." The children needed direction not only in making the first approach in playing with each other, but also in responding appropriately. The children seemed to get great satisfaction from the suggested forms of play, which they repeated session after session.

Some basic steps

The success of the play group program has convinced us that a mother and her retarded child may best be helped in a group setting. Counseling the mother alone in the office or in the home does not suffice. Although we readily acknowledge the differences in bringing up retarded children and normal children, we feel that any program for retarded children should build in an approximation of normal events without skipping basic steps.

In our play groups, we stress helping the child develop object relationships, to establish first an awareness of self with feelings, capacities, and desires, and then a similar awareness of mother, teacher, and peers. From this viewpoint, the total absence of any separation reaction in a child seems ominous. Therefore, we attempt to evoke the expected normal response from the children. We enlist the mother as an active collaborator, since we are trying to strengthen the mother-child relationship. We have tried to avoid the establishment of what might be called "splinter skills"—that is, oral recitations, rituals, and other behavior forms that have no meaning to the child.

Our observations have indicated that when mentally retarded children have achieved the ability to separate from their mothers and to adapt to a group, they are ready to learn skills and to profit from an educational program designed to compensate them for their cognitive deficits. Possibly, the dependency and "outer-directedness" [5] that is characteristic of so many retarded persons results from early failure to establish a basic sense of autonomy and identity.

The play group program is probably a luxury that cannot be widely replicated. It can only serve as a demonstration of certain principles. We believe that we have demonstrated that young, mildly retarded children do have separation reactions that deserve attention. Even with the severely retarded child, the teacher should anticipate some regression of behavior and try to minimize the effect of the strangeness by having the mother present for an initial period of time. The mother should be well acquainted with the teacher and participate in the program so that she can talk about it at home. In turn, the teacher should know about the other members of the child's family, his pets, and home activities so that she can discuss them with the child at school. The curriculum should place considerable emphasis on "mother"—where she is now, what she is doing, and the reunion with her.

A child often disguises or delays reactions to separation by refusing to cooperate with the teacher. If this happens, it may be wise to bring the mother back into the nursery school. However, the child may be able to master his feelings if the teacher helps by recognizing and accepting them. Perhaps what is most important is that the teacher should not be reluctant to have the child show that he misses his mother. To miss his mother is a normal reaction in a child and casts no aspersions on the teacher's skill with children or her nursery school program.

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[4] Ablon, G.: Comparison of play of retarded and average children. Unpublished doctoral dissertation, Case Western Reserve University, Cleveland, Ohio. June 1967.

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EARLY CHILDHOOD EDUCATION

FOR WHAT GOALS?

MILTON J. E. SENN, M.D.

There is today a cleavage between educators of young children who favor educational practices based on concepts of the child in relation to his *whole* emotional-cognitive development and those who favor practices aimed only at developing certain measurable skills defined as "intelligence."

In my opinion the sane perspectives on the hierarchy of values have been turned on end. We are now urged to believe that highly structured, mechanical, and rigid practices in teaching are superior to those that are flexible, child-experience oriented, and focused on human relationships. We are being led to expect both immediate and lasting results from programs aimed at speeding up the learning in the youngest minds. Emphasis on the intelligence quotient as the measure of achievement continues despite strong evidence that questions the validity of this practice.

Obviously the changing nature of societies forces a reconsideration of how to educate a new generation. The Russian launching of Sputnik in 1956 triggered a near phobia about making American minds equal, if not superior, to those of our cold war competitors. More recently the civil rights movement has moved us as never before to take stock of our human resources. Now there is a readiness to accept the long-held premise of persons in the field of child development that the beginnings of waste start in the early years, and research in the education of young children is proliferating.

We have had few great educational theorists in the United States other than G. Stanley Hall, John Dewey, and William James to lead the way. For the most part we have looked to foreign countries for basic theories about the nature of man, his attributes, and his needs and for concepts of how these are to be dealt with educationally—to such geniuses as Jean Jacques Rousseau, John Locke, Henry Pestalozzi, Friedrich Wilhelm Froebel, Maria Montessori, and of course Sigmund Freud. To this list has recently been added the contemporary Swiss epistemologist, Jean Piaget, who has had a profound influence on American psychologists and researchers in child development since the early 1950's.

Piaget's influence

Piaget and his colleagues in Geneva are primarily recognized for the work they have done in the field of cognition, although Piaget has been mostly concerned with the nature of knowledge and with the structures and processes by which it is acquired. His discoveries that experiences in the first 5 years of life are vital and long lasting and that infantile sensory-motor coordinations are forerunners of the form and content of adult thought substantiate the theories of Freud. While Piaget is informed about Freudian theories and has long realized the importance of emotional processes in learning, he has said that time has limited his considerations to study of *intellectual development* and that he would leave to others the consideration of *feeling states* and their relationship to learning. However, few of his disciples in the field of experimental psychology have been inclined to integrate their research on cognition with research on personality development.

Piaget views the growth of the structures of know-

Condensed from the first Evangeline Burgess Memorial Lecture presented at Pacific Oaks College and Children's School, Pasadena, Calif., April 3, 1968.

ing as proceeding over time, beginning in early infancy and ending in adolescence.[1] Not only is there a distinct beginning and ending in the schema he presents, but there are also certain *critical periods* along the way. Human intelligence (or knowing) begins with the phase of sensory-motor responsiveness. The infant is equipped by heredity and constitution with reflex patterns for reacting to touch, vision, sound, and kinesthesis; his behavior is shaped by external demands imposed by the environment; response to these demands goads his mental growth.

As he assimilates his experiences, the baby learns strategies for coping with both external and internal demands, and with time he organizes the information he has acquired into systems. By the end of his first year the child is able to construct a theory of the world that transcends direct sensory experience, as when he appreciates the existence of an object he cannot see and develops skill in searching for the unseen. By the time he develops language, which is dependent on his sensory-motor functions, he is more manipulatable in thought and more susceptible to social correction. We say he is able to "internalize his actions," to use his mind and proceed from perception and manipulation to reflection.

The phases of intellectual development follow each other, not in strictly chronological fashion, but in a sequential and orderly manner from early infancy into early adolescence. Piaget believes that these phases may be accelerated to some extent by manipulating the environment but that such manipulation will only be effective up to a certain point. The environment *is* important but only as a child is able to pay attention to it, and this ability depends on the degree of assimilation which has taken place. However, the greater the *variety* of experiences a child copes with, the greater becomes his ability to cope.

Piaget never points to any practical implications of his work. Aware of what some of his followers are doing in the application of his studies to the education of young children, he has issued a timely warning by inquiring, "What is learning for—to know a certain *number* of things, or to be capable of creating or inventing new things?"

There continues to be much unclarity in the minds of many of Piaget's adherents about the meaning of the term "cognition." Piaget himself, pointing out that his theories are unfinished, continues to change his emphasis, concepts, and terminology.

Cognitive psychologists interested in infant behavior and learning have also found encouragement in the research of other scientists who have studied babies reared in different environments. René Spitz and others, for example, have reported harmful effects of impersonal care and understimulation suffered by babies reared in foundling hospitals.[2] Although the emphasis in such research was at first on affect deprivation, later investigators have reported damage to cognitive functions as well.[3]

Early stimulation

For the past several years there has been a burgeoning of investigation into the physiological, psychosocial, and intellectual deficiencies resulting from understimulation and of efforts to prevent and ameliorate deficiencies by sensory stimulation. Studies of sense organ stimulation in newborn infants have had special appeal to investigators. Often this research has resembled the experiments conducted in Russia for over a decade, in Moscow under A. S. Louria and in Leningrad under the Pavlovian-trained pediatrician Nicholas Krasnagorski. The American investigators, like the Russian, have found that a baby not only changes his physiological reflex responses after sensory stimulation, but that he learns to change his behavior if he feels rewarded by the process of stimulation. For example, newborn babies learn how to change their rate of sucking and how to move a mobile with their toes when pleasurably stimulated by sight and sound. The inference from such findings is that babies can learn more than we realize if they are taught by techniques that stimulate the nervous system.

The Russians believe that through conditioning they can overcome the ill effects of prematurity very early in infancy. While this theory has never been validated elsewhere, many American cognitive psychologists believe that through early stimulation of the central nervous system of normal babies, they may speed up their intellectual development so that by the time the children are 4 years old they will be greatly beyond the normally expected level. Since it is commonly believed that by age 4 a child has attained half of his final intellectual capability, the race seems to be on not only to have American children attain their full intellectual potential before adolescence, but to keep it increasing to a higher degree than is normally attained.

Some cognitive psychologists believe that future generations can reach 30 IQ points ahead of the present generation through better management of their early environment, beginning in infancy. Yet the

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definition of intelligence remains unclear. Moreover, there is no agreement on the details of *how* and *when* to manipulate the environment.

In reviews of the research on stimulation of infants, one rarely finds words of warning or descriptions of any harmful effects of early stimulation. But the research of Burton L. White of Harvard points in that direction.[4] In studying institutionalized infants, he found what Spitz and others had described: delays in motor response due to lack of visual stimulation. In attempts to find ways of preventing such deficiencies, White studied a group of 6-day-old normal babies in a hospital. He saw that they got more physical handling, more opportunity to look around, and more bright objects to see than is usual. He found that this special stimulation upset the babies; they cried a lot and paid less attention to their surroundings. However, when he provided similar ministrations to babies 2½ months old, favorable responses resulted; these babies smiled at objects, vocalized, and seemed happier than unstimulated controls. Thus, the timing and amount of external stimulation are important.

The Russians report that although a newborn baby may be helped to mature more rapidly by conditioning, all newborns do not respond favorably to such treatment. This is because there is a basic difference in equipment in each individual, which makes the *timing* of the conditioning important. As one would surmise, the more mature babies respond more favorably than the less mature. Nevertheless, in Russia all normal newborns in hospital nurseries are stimulated visually and aurally; "teachers" sing to them at prescribed times each day, dangle colored rings before their eyes, and shake a tambourine next to their ears.

John L. Fuller, senior staff scientist at the Jackson Laboratory in Bar Harbor, Me., has also substantiated the theory that timing and quality of stimulation are important. Experimenting with dogs, he discovered that animals that had been isolated and deprived of sensory stimulation from birth could be helped to overcome their deficits only if the changes in their environment were made gradually and in a way that permitted their sensory-motor capacities to adapt slowly. When the transition from the depriving to the stimulating environment was made too rapidly, the adaptive mechanisms were overstrained and the dogs became especially fearful.[5]

Fuller described another important aspect of appropriate stimulation when he reported that only when the stimulated animals' stress was reduced by stroking and handling were they able to make any contact with other objects, whether toys or humans, without irrational fear. These observations tend to verify the conviction of many teachers that contact with humans is more important than stimulation from impersonal objects and that human relationships are the primary factors in helping children to learn.

Other psychologists have found that children who have been deprived and are abruptly exposed to new stimulating experiences do not learn readily, because they become excited and have less control over their impulses than usual.

Another researcher speaks to the question of appropriate quality of stimulation when he describes his longitudinal studies on infants from 4 months to 4 years of age. Measuring how much babies in the first year of life perceive and understand of their environment, Jerome Kagan of Harvard University observed differences between babies from different socioeconomic backgrounds. The *distinctiveness* of the stimulation, more than the *amount* of stimulation, marked the difference between children from middle and lower socioeconomic groups. Kagan has concluded that learning should be fostered in infancy through a *distinctive* (not yet clearly defined) stimulation provided by parents and that all parents need education about this process. He also believes that the classroom environment for children must be designed to fit the child's needs, and that these needs vary according to the child's early rearing.[6] Thus, inappropriate stimulation, as well as overstimulation, may be as disastrous for children as understimulation.

Preschool programs

Awareness of the great difference in learning between slum children and those reared in more affluent circumstances led to the founding of Project Headstart in 1965. Unfortunately, it was begun as a crash program, without sufficient time to recruit well-trained, experienced teachers. Many of those who accepted teaching and administrative roles received only short periods of training before they began to work. Often they did not know the characteristics of children aged 3 to 5 years of any racial or socioeconomic background, nor how to fashion appropriate learning opportunities, and they were unprepared for the upsurge of their own feelings in dealing with the children brought to them. Therefore, many of the Headstart classes have failed to give children enough of the kinds of experience they most needed.

This is not to say that gains have not resulted from Headstart. Although the greatest gains may

come from the early recognition of disease and the correction of physical defects in children who otherwise would not have received any medical care, children may also have gained educationally by becoming better informed about themselves, their neighborhoods, and the world around them. Too frequently, however, Headstart programs have failed to teach children what they were ready for, such as a better use of language for communication. On the other hand, in a few sophisticated urban communities, the Headstart program has become a pawn in the struggle between advocates of differing methods of early childhood education.

Some critics of the standard, play-oriented nursery school approach have recommended more structured and didactic methods of teaching, not only for Headstart but for all early childhood education. A program originated by Siegfried Engelmann and Carl Bereiter at the University of Illinois concentrates on teaching children certain special *items* which these experimenters believe every child must know when he enters first grade. The program has three distinctive characteristics: (1) a high ratio of teachers to students, (2) reliance on drill, and (3) learning by rote. Children are made to repeat after the teacher the names of objects, numbers, and descriptions of various items held in front of them. No deviation of response is permitted; there is always only one right answer. The children are asked to answer in unison as well as individually. There is little tolerance or time for an original idea or an association spontaneously expressed. The conditions are conducive neither to curiosity nor to learning the connections between the things recited and things experienced.

This method of teaching will be remembered by many older persons as the kind they experienced in school. However, it differs in one respect in that the young pupils are not expected to sit impassively with hands folded. The children are encouraged to recite as a group with simultaneous loud clapping of hands and other rhythmic movements.

In watching any of these classes, one is impressed with the seriousness of the work at hand. The emphasis in learning is on work, not play, and on making everything count as if time needed to be conserved. Disapproval of mistakes is expressed not only in strong words but occasionally by slapping a child's hands, as if to emphasize that a person must feel guilty when he makes mistakes and that errors are similar to misbehavior in being punishable.

It is not easy to determine the effects of this kind of teaching on children. Engelmann and Bereiter have been pleased that their children learned to speak in sentences, progressed in arithmetic, reading, and spelling, and in general increased their IQ levels.[7] There are reports that the children have made gains in psycholinguistic ability. There are also reports that the children are very often tense and frightened and respond automatically. Some child development specialists doubt whether the results of rote learning will carry over into the later years of schooling and suggest that the children may even develop a fear of and distaste for school.

A group of children in a Headstart program react with varying degrees of interest to the book the teacher is showing them.

The question arises as to whether children taught by these methods have really learned to think, to reason, and to conceptualize, or merely to parrot unquestioningly whatever they are told by authoritarian teachers.

In an experiment at the University of Florida, mothers of very young babies are being taught in well-baby clinics how to use toys so that their children will learn concepts of size, relationships, and color. This program is similar to one in Russia wherein mothers are taught how to play with their children and to use toys recommended by the polyclinic staff. The Florida experimenters, like the Russian, emphasize attention to small muscle movements, exercises, and body massage as ways of producing kinesthetic stimulation and fostering mental development. Here again, the emphasis seems to be on how to get the children to learn *more* and to develop various *skills* without any attempt to foster their creativity or individuality.

Teaching the use of toys in such a didactic man-

ner resembles the methods of Montessori. This Italian physician-educationist worked with slum children 3 to 7 years of age in a day-care center in Rome in the early part of this century. She invented educational toys and used them in didactic teaching to help children develop their intelligence. She also sought to inculcate discipline and good habits of study. But in contrast to some present-day American educators, she was also concerned with the cultivation of independence and curiosity as well as persistence in learning.

The Montessori system never really got started in the United States until about 10 years ago, when it suddenly spread across the country. However, there have been so much unorthodoxy and deviation from the original methods that it is rare to find two Montessori nursery schools in which the methods are applied alike. The revisionists have tended to favor modification in the use of the equipment, flexibility in programing, and more free play.

What the long-term effects of these various techniques will be remains unclear. Those researchers who are providing more stimulation to children have not demonstrated that sensory stimulation enhances the use and understanding of symbols, which are necessary for the development of a sense of meaning. Those who use teaching machines acknowledge that unless wisely used such products of educational technology could destroy initiative and individuality, "making all men alike and not necessarily alike in nice ways."

Barbara Biber of the Bank Street College of Education has pointed out that "the method, through its effects on attitude and therefore on motivation, becomes a secondary determinant of how far the original learning goal will be realized." [8]

Defining goals

Program planners today in discussing appropriate goals for early childhood education show little understanding of *the difference between intelligence and intellect* and to which of these qualities educational efforts should be directed.

The historian, Richard Hofstadter of Columbia University, however, has given much thought to the differences between intelligence and intellect. "Intelligence," he says, "is an excellence of mind that is employed in a fairly narrow, immediate, and predictable range. Intellect on the other hand is the critical, creative, and contemplative side of mind. Whereas *intelligence* seeks to grasp, manipulate, reorder, adjust, *intellect* evaluates and looks for the meanings of situations as a whole. It implies a special sense of the ultimate value and the act of comprehension. Socrates struck its essence when he said that the unexamined life is not worth living." [9]

Milton J. E. Senn, M.D., Sterling professor of pediatrics and psychiatry at Yale University, was until his retirement in 1966 director of Yale's Child Study Center. Among his recent publications are two books, "Problems of Child Behavior and Development," which he wrote with Albert J. Solnit (Lea and Febiger) and "The Firstborn: Experiences of Eight American Families," which he edited with Claire Hartford (Harvard University Press and Commonwealth Fund).

In assessing the effects of programs, emphasis too often has been on measuring cognitive development or other learning on the basis of changes in IQ scores. Many of the new teaching techniques do seem to bring about significant increases in IQ scores. Others, however, do not effect gains as measured by tests, yet do help disadvantaged children develop skills they would not otherwise have. This discrepancy between test results and achievement has led clinical psychologists to reappraise the standard tests of intelligence, and to attempt to design substitutes that take into consideration the tested child's cultural heritage and areas of deprivation and that can detect gains in ability to learn as well as changes in IQ.

Martin Deutsch of the Institute of Developmental Studies, New York City, in discussing the relevance of intelligence testing to work with socially deprived children, warns that the current faith in test results tends to overshadow another worthwhile source of evaluation—reports of individual teachers. He points out that teachers stimulate *curiosity* and *initiative* in children, two characteristics that the usual testing in schools does not measure.

In early childhood education, as in all child care and rearing, we should be concerned with the "whole child," the total self, not just the development of certain mental characteristics or the learning of skills. The conception of the whole child need not be as generalized, vague, or overflowing with inspirational platitudes as some people have made it. The "whole child" represents a composite organism, the physical, emotional, and social self that learns through a variety of processes, cognitive learning being only one

important component and one which also involves feelings and emotions.

When I say I believe in helping children experience joy and happiness in learning, I do not mean protecting them artificially against the crises of life or from all experiences of fear, anxiety, and unhappiness. When I say I want children to feel free to ask questions, to explore, to experiment, to be spontaneous, I am not advocating license in a classroom that is unsupervised or led by a teacher who is incompetent or irresponsible. I expect teachers to be informed about appropriate curricular materials, but also to know how to incite the deep interest of children through their teaching skill and their relationship with pupils, without resorting to pedagogical tricks. I expect educational programs to help children find themselves as individuals—learners, thinkers, doers, persons with feelings, increasing clarity as to their identities, and appropriate roles in life. Such programs can be based on sound experimental studies of learning and teaching and the results evaluated by rigorous methods that go beyond the measurement of changes in IQ.

Herbert J. Muller puts it this way: "What is needed, under any name, is the view of the biological whole man, a view in which we can make out the full value of the rational, but also the necessity of the nonrational—feeling, sentiment, desire. The activities of the higher motor centers, known as the exercise of reason, are the most advanced point in man's development, the finest means of adaptation; but they do *not by themselves* actually run man. They belong to a nervous system, which, in turn, is subordinate to the system of needs and purposes that is the whole organism." [10]

It seems to me that, at the very least, our goal should be the enhancement of all those factors that inevitably interact and foster the appropriate development of all parts of a child as he moves from infancy to childhood, then to adolescence and to adulthood. This will include the environmental, emotional, social, psychological influences as well as the cognitive and all other elements involved in learning. Above all we should avoid the myopia of fragmentation wherein understanding of the whole organism is obscured by focus on a part.

Children do need to learn how to adapt to a rapidly changing world, but a speedup in their learning, in skill proficiency, does not guarantee ability to cope with life at any tempo. Too frequently today the emphasis is on speed, on hastening learning. Children are denied time to reflect, to cogitate, to dream. I believe this denial hinders the development of the intellect as distinguished from development of intelligence.

By concentrating on intelligence and discouraging intellect, current educational methods may lead to the unexamined life deplored by Socrates. Yet without the ability to examine life, the individual is impoverished and society is deprived; it could be that without the ability and the will to examine life we may stop living.

What goals are we striving for in education and child rearing? My personal hope is that our passion for mass education will be founded primarily on belief in the desirability of developing the mind, and on a pride in learning and culture for their own sakes, rather than on political or economic benefits; and having set that goal, that we will implement it by doing whatever is necessary, so that we may finally realize the kind of education we have idealized in words for over 200 years.

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A PSYCHOTHERAPEUTIC AIDE IN A HEADSTART PROGRAM

I. THEORY AND PRACTICE

MICHAEL P. ANDRONICO • BERNARD G. GUERNEY, JR.

The purpose of Project Headstart is to help children from disadvantaged backgrounds achieve intellectual levels nearer to other children by the time they enter kindergarten. This faces the programs not only with the necessity of motivating these children to learn, to make up for deficits in intellectual stimulation in their homes, but also with the problem of dealing with many children whose learning potential is hampered by emotional difficulties.

For a number of reasons children from lower socioeconomic backgrounds are difficult to reach through child guidance clinics. Headstart nursery school may be a much more realistic setting in which to provide psychotherapeutic treatment for disadvantaged children than a conventional child guidance clinic.

But a shortage of available professional persons in the mental health field precludes the extensive use of professional persons for direct psychotherapy with children in a Headstart program.

On the theory that nonprofessional persons may successfully serve as child psychotherapeutic aides in Headstart projects, the Riegel Ridge Paper Foundation Headstart Project in Milford, N.J., has experimented with the treatment of emotionally disturbed children through a nonprofessional neighborhood worker who had previously been trained in the principles of play therapy through a "filial therapy" program.

In its unmodified form, filial therapy is a method whereby parents of emotionally disturbed children work with their children at home for brief periods of time, using the principles of child-centered (Rogerian) play therapy [1, 2] taught to them by professional therapists.

Parents learn these principles in groups of five to eight, which meet regularly for 2 hours a week. The aim is to provide the child with a time during which he receives unconditional attention, respect, and acceptance from an adult important to him and during which he can express his own wishes, needs, and feelings through imaginative play and through interaction with the adult. This type of experience over a period of time is expected to allow the child to become more aware of his true feelings—positive and negative—to resolve conflicts about his feelings and learn to express them in appropriate ways, and to develop the kind of positive regard for himself and for others so often lacking in troubled children.

During the first group session with the parents, a professional therapist briefly explains the principles of play therapy and encourages the parents to express whatever feelings they have about the therapeutic role they are being taught to take. In the next few sessions, the parents observe the therapist taking the play therapy role with their children, one at a time. After a few weeks, each parent has an opportunity to demonstrate in a play session with his or her own

child what has been learned while the group and the therapist observe the session through a one-way mirror. This enables the group and the therapist to point out errors in the parent's technique.

Once the therapist decides that the parents feel enough confidence in their new role, the parents begin to carry on therapeutic play sessions at home. However, they continue to attend the weekly group meetings where they discuss the home sessions with the therapist and each other and to carry on demonstrations to give the therapist an opportunity for direct supervision.

Selection and training

The Riegel Ridge Headstart Project was fortunate in securing a person on its staff who had already been trained to conduct therapeutic play sessions with her own child. But there is no reason why the same methods used to train persons for filial therapy could not be used in training persons to work with other people's children. Some prejudgment of aptitude, based on evidence of intelligence and warmth, would have to be applied in selecting the trainees, but most important in the final selection of a psychotherapeutic aide would be the observation of the person's ability and skill during the training period.

The therapist would teach the aides such techniques through demonstrating them and then would observe demonstrations by the aides-in-training. Since the essential ingredient of the play therapy is an atmosphere of total acceptance and understanding so that the child will no longer repress his feelings, the supervisor-trainer would have to be constantly on the alert for any evidence of rejection of the child or any of his feelings on the part of the aide. At the same time the aide would have to be taught the importance of properly enforcing the rules of the session. Supervision of the aides after training to detect and correct any errors in techniques that might arise would, of course, have to be continued throughout the duration of the program.

As in filial therapy, the training would involve teaching the aides (1) to try to understand how the child presently feels; (2) to accept the child's feelings no matter what they are; (3) to allow the child always to take the lead in determining how he uses his play time; (4) to enforce the rules of the session with complete firmness while remaining empathic and noncritical; and (5) to demonstrate to the child that his needs are indeed being understood and accepted, by making appropriate but brief statements such as, "That gets you angry," or "You really like Joan"—in other words, verbally "reflecting" his feelings so that he will grow to recognize and express them.

The first part of the training of nonprofessional persons for such a task might take place in a training group of general child-care aides. Persons showing a special ability to empathize with children, to communicate their understanding to the child, and to be firm or permissive at appropriate times might then be asked to take further training to become psychotherapeutic aides. Such a program would, of course, only be possible if a psychologist, psychiatrist, or psychiatric social worker with special skills in nondirective play therapy were available to the project for training and supervising the aides.

Headstart experiment

The woman employed as a psychotherapeutic aide by the Riegel Ridge Headstart Project had previously been taught the methods of child-centered play therapy in a filial therapy group at the Hunterdon Medical Center in Flemington. A high school graduate in her late twenties, she had achieved a high degree of success in helping her own child. During her employment as a psychotherapeutic aide she has demonstrated that she can also be successful with other people's children.

Soon after the beginning of the 1966–67 term, the project referred six children to its psychological consultant. The reasons for referral ranged from uncontrollable behavior to withdrawn, overly inhibited behavior. The psychologist determined that all six children were in need of psychotherapy because of intense emotional problems and recommended that this be provided under his supervision through the psychotherapeutic aide. The aide began having regular 30-minute therapy sessions with each child twice a week. She would take the child out of the classroom and drive a half mile to the Riegel Ridge Community House, where a room was available for the play therapy session. After the session, she would return the child to the Headstart class and then take the next child to the Community House.

This procedure was followed twice a week for 16 weeks. The aide took notes on every session for use in her conferences with the psychologist. During the first conference, the psychologist outlined the essentials of each child's background and explained the child's needs and the motivations for his behavior. Specific questions discussed in subsequent supervisory

conferences concerned the subtleties in technique, such as how to keep from discouraging the child from expressing negative feelings, and when and how to tell the child that the sessions would end with the school year. The psychologist also encouraged the aide to accept the child's expressions of positive feelings, for example, to allow a child to sit on her lap if the child so desired.

At all times, the supervisor felt confident that the aide was performing her role well and that no child was adversely affected psychologically, even temporarily. This is not surprising, since the aide's role is a nondirective one and does not involve interpretation of the child's behavior to the child.

The case of Carolyn

All six children treated by the aide showed signs of improvement during the period. The case of 4-year-old Carolyn is illustrative.

At the time she was enrolled in the Headstart nursery school, Carolyn and her mother, stepfather, and 7-year-old brother were living with her maternal grandparents. The mother's first marriage had ended in divorce and the mother had only recently remarried. The grandparents had always borne the responsibility of caring for the children, but the grandmother had developed a closer relationship to Carolyn's brother than to Carolyn. On the basis of his observations of Carolyn and information available to him, the psychologist noted that Carolyn was very withdrawn and afraid of strangers, but probably had average intellectual ability.

Usually a fearful, withdrawn child first reacts to play therapy by being very quiet and inhibited. He then gradually becomes more exploratory and begins to play alone with the various toys made available for the session. After a few sessions, he expresses himself more directly in his use of the toys and acts out some of the underlying hostility and repressed feelings which his withdrawal symptom has been covering up. He usually begins to express direct hostility toward the therapist by littering the room, speaking angrily, or breaking a rule. In a successful case, after these middle stages of direct and aggressive acting-out behavior, he shows signs of developing appropriately controlled self-expression. That is, in contrast to both the initial stage of extreme withdrawal and the middle stage of cathartic aggression, he becomes more flexible and expresses his feelings directly but in more socially acceptable and appropriate ways.

Carolyn's behavior in the play sessions with the psychotherapeutic aide followed the expected sequence. During the first play session, she sat the entire time without playing or interacting in any way with the psychotherapeutic aide. Only when the aide told her that there were just 5 minutes left of the session did she make any attempt to play, and that was only by taking a piece of clay and rolling it into a ball. The aide's notebook comment on this session was, "Carolyn appeared very unsure of herself, and seemed to be looking for direction and approval."

In her second session, Carolyn behaved in a similar fashion, waiting most of the session before picking up the clay and again simply rolling it into a ball. However, she eventually took up some crayons and scribbled on a piece of paper. The aide noted, "Carolyn acted much more friendly today, but at times was still unsure of herself."

In the next two sessions, Carolyn gradually became more at ease, spoke freely, and began to touch and play with some of the other toys in the room. However, she frequently sought the approval of the aide. At the same time, the aide noted that Carolyn was beginning to test whether she would be rejected if she displayed provocative behavior. For example, she would drop her crayons and paper on the floor, then look at the aide and laugh. Once, she inadvertently broke a crayon and then looked at the aide fearfully and said that the crayon broke by itself. She appeared quite relieved when the aide did not scold her but merely said, "That frightened you."

As the sessions continued, Carolyn gradually gained more confidence and began to vary her activities, using the toys freely and romping about.

She also began to involve the aide in her play. For example, she pretended that the aide was her mother and that they were having a party. Then, after say-

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ing she was going to clean off the supper table, she swept everything onto the floor and laughed, thus indirectly expressing her hostility toward her mother. After a while she began to express her anger more directly by throwing a bop bag around the room. She continued to express hostility toward the aide. She would tell the aide to draw along with her, but then would take both crayons, leaving the aide with none.

In later therapy sessions, Carolyn continued to express her hostile feelings in such ways. She also began to display some affection for the first time, putting her arms around the bop bag and saying, "Look, I'm hugging it." The aide reported this as a sign of progress, for she had learned that such a spontaneous display of affection usually occurs only when a child has expressed many of the negative feelings that have been blocking the more positive feelings.

Carolyn also became able to work directly on other feelings such as fear. For example, at one session she heard a dog bark and ran to the aide saying that she thought she heard a monster. When the aide said, "You are afraid, aren't you?," Carolyn freely admitted that she was. After repeating expressions of her fears and listening to the aide's "reflections" of them, she walked away and said, "I'm not scared now. I don't think it could be a monster."

The results

At the time of the last few sessions, Carolyn's family was about to move from the grandmother's home, and Carolyn began to talk about how she felt, both good and bad, about this. The aide responded with such empathic statements as "You're happy to be going someplace new but it makes you sad to leave Grandma."

Carolyn also began to express her feelings about herself. Once remarking that her hair was a mess, she picked up a girl doll and threw it down saying it had a "stinky hairdo." But she also learned to be more accepting of herself and her feelings. For example, although she said she disliked the drawings she had made, she asked the aide to put her name on them. Previously she had always torn her drawings up.

Throughout the 16 weeks of sessions, the aide continued having discussions with the psychologist about the meaning of Carolyn's behavior and ways of dealing with it.

By the time the series of sessions ended, Carolyn showed signs of real improvement in the Headstart classroom. When she first came to the Headstart nursery school, she was a very shy anxious child who lacked the social skills necessary for assimilation into the group and who responded to any adult direction either with a temper tantrum or with sulking. Gradually she became a smiling, chattering youngster who generally responded to adult direction with little objection. Her teacher attributed much of the improvement to her experience of achieving total acceptance from the psychotherapeutic aide.

ONE CANNOT EVALUATE accurately the effectiveness of a program to improve the adjustment of a small number of emotionally disturbed children in such a short period of time without a control group to gage the contribution which the play therapy provided over and above the contribution of the Headstart classroom experience. However, the fact that all six children showed a degree of improvement similar to Carolyn's gives us reason to believe that the play therapy carried out by the psychotherapeutic aide was effective. We tried to interview the mothers of the six children at the end of the first year of the project to learn their opinions of the experience, but were able to reach only four. Their responses were uniformly positive. For example: "Billy seems to be more relaxed . . . I am very much satisfied with his progress." "Donny has changed a lot. He plays with the kids much better now."

At the end of the Headstart term, the teachers reported that each of the six children was generally more relaxed and more adaptable to the program and to changes in activities.

Obviously, subjective evaluations by persons who are aware of which children received special treatment are far from adequate evidence of a program's effectiveness. At the present time, because of the shortage of funds, plans to launch a program of this type with provision for objective evaluation have been temporarily put aside. However, the psychotherapeutic aide, under a professional therapist's supervision, is continuing to provide play therapy to children with obvious emotional difficulties. We believe that the results are encouraging enough to suggest that other Headstart programs should train, use, and evaluate the effectiveness of adequately supervised nonprofessional people in this sort of role.

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A PSYCHOTHERAPEUTIC AIDE IN A HEADSTART PROGRAM

II. COMMENTARY

All of us who have been working with children in Headstart programs have recognized that perhaps 10 to 20 percent of the children enrolled are not able to make full use of the Headstart experience without special help. The kind of help provided by the psychotherapeutic aide described by Andronico and Guerney is an example of one kind of special assistance children may need.

Before proceeding to help such children, however, we need a solid understanding of the sources of the child's difficulties. A wildly disruptive, hyperactive child may have organic problems requiring medical help first of all. Therefore, any hyperactive child, and also any child who does not speak, should be given a thorough examination by a pediatrician who has been fully informed about the child's difficulties in Headstart. In some instances the child may also need a full psychiatric evaluation. Only when it is clear that the child does not need medical help or if he does, that a plan has been made to provide it, should any kind of special psychotherapy be attempted.

Secondly, we need to determine carefully how the child's experience in the group might be modified. In England some excellent therapeutic work has been done within groups, so that the child does not lose time from the group experience. If the activity room is spacious, room dividers can provide a quiet corner where a therapist can work with an individual child in a process similar to that described by Andronico and Guerney, without requiring the child to become oriented to a completely new setting. If a protected corner of the room is not available, another room in the same setting, such as the teacher's office, might be used for the purpose.

The helping process described by Andronico and Guerney seems to imply that the child is ready and willing to make use of the play materials offered him. Actually, some children are by no means ready for this. One finds children who are extremely hostile to or fearful of other children or adults, who are preoccupied with one activity, or who are terrified of play objects or expressive materials. To such children the therapist may have to take a special approach for a while, such as keeping distant enough that they do not feel threatened, then moving quietly and gradually toward a closer relationship. For some children nonverbal communication lets the child know that the therapist is not going to move any more rapidly than the child wants him to. This may be more important than any words that the therapist can use.

With other children it may be desirable for the therapist to take active steps to help the child feel comfortable. Subtle cues often communicate a child's wish for the adult to remain at a distance or to come closer and play with him. If the child moves toward the therapist, looks at him wistfully, or arouses an empathic intuition that he wants to be cuddled or held, the therapist may find that overtures to the child help to release his spontaneity. Again, the accuracy of the therapist's perception of what the child really wants him to do is more important than words.

The child who seems obsessively preoccupied with one toy may respond gradually if the therapist plays

with a similar toy, gradually expanding the kinds of things he does and then introducing other toys step by step. For example, if a child is afraid to use finger paints, verbal comments on his feelings may not be as effective as allowing him to watch the therapist experiment with the finger paints in the way a child usually does. The child may then infer that it is all right to experiment with the paints himself. Such preparatory stages are needed by some children before they can move into the kind of relationship in which verbal comments on play are helpful.

I would underscore the authors' statement that "the essential ingredient of the play therapy is an atmosphere of total acceptance and understanding" and also their point about the importance of setting and firmly adhering to certain limits in regard to the child's behavior—the child cannot be allowed to hurt himself or the therapist. I would also underscore their emphasis on "trying to understand how the child feels, to accept the child's feelings no matter what they are, and to demonstrate to the child that his needs are indeed being understood and accepted." Some anxious, inhibited children may need the support of gentle initiative from the therapist. Recognizing the child's feelings with such phrases as, "That's scary," "That makes you cross," is a part but not necessarily the major part of play therapy; in some instances the child may do his own kind of "working through" by means of his activity with the toys.

However, a rigid difference should not exist between a therapist's way of helping a child express his feelings and a teacher's way. I have often heard a teacher remark that if she said anything to a child about his feelings she would be overstepping her responsibility, for commenting on feelings "belongs to therapy." This attitude puts a thoroughly unnatural limitation on the teacher's normal communication with children. Teachers of preschool children have to help the children learn about their environment and the names of everything in it, to help them make comparisons—for example, about what is soft and smooth or rough and scratchy—and to learn concepts of space and time. But human feelings are just as much a part of life as things and concepts. A teacher should be able to comment naturally that Johnny made Billy very angry when he knocked down his skyscraper; or that one feels lonesome and worried when one's mother has to go away to the hospital. Talking about feelings should be a natural part of everyday life.

I question the advisability of a parent giving therapy to his own child. An understanding and accepting attitude toward children's feelings should be a normal parental response, and can be even when parents find it necessary to set limits. For example, a parent might naturally say, "Johnny I know you were mad at Billy when he bumped into your airport, but I can't let you hurt Billy. Tell him to be more careful." In other words, openness and exchange of feelings should be a part of home life. However, for a mother to set a special time to provide her child with "unconditional attention, respect, and acceptance from an adult important to him" seems to me pathetically stilted. I should think it would be confusing to the child to have his mother act one way at one time and another way the rest of the time. At best it is a roundabout way of providing what all parents should provide their children naturally.

Parents, of course, can learn something from watching what therapists do. I would be interested in an experiment in which parents of Headstart children were allowed to observe a therapist with a child through a one-way mirror and then participate in a discussion of what part of the therapist's work could only be done by a therapist and what part could be done by parents.

The supervisor is necessary to any therapeutic un-

By blocking herself off, this preschool child may be trying to assuage anxiety brought on by the presence of other children. Some children need help in adjusting to the group.

dertaking by a nonprofessional person and might be either a psychologist, social worker, child psychiatrist, or pediatrician—any professional person who is thoroughly acquainted with the world and feelings of the preschool child and the implications of therapeutic attempts. Children who are disturbed enough to need special help often exhibit outbursts of anxiety or anger, breakdowns in control, or distortions of thinking, and the therapist with little training and educational background needs help from an experienced supervisor in understanding and dealing with such occurrences. It would be absolutely unsound to let aides who have had only minimal training undertake therapy unless responsible supervision were available at all times.

I feel that it is of the greatest importance to provide Headstart teachers with special help for the children who need more attention than any teacher can provide an individual child, but appropriate supervision must be provided and the helping process adapted to the widely varying needs of individual children.

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The need for more adults trained to assist young children who have been deprived or blocked in their development is a critical one. However, I seriously question the assumptions of Andronico and Guerney in relating their experiences in training and using a psychotherapeutic aide in a prekindergarten program. Since this plan was derived from a previous therapeutic program in which mothers were trained to treat their own disturbed children, a discussion of it must begin with an examination of what the authors call "filial therapy."

The concept and techniques of filial therapy erase the vital difference between the functions of a mother and of a therapist. The maternal person offers the child affection, protection, guidance and the stimulation, gratification, and limitation suitable to the needs of the developing child and reflecting the mutuality of child and mother. In their confusion between therapy and maternal care, the authors recommend that a mother set aside regular times for appointments with her disturbed or psychologically ailing child, during which she carries out the functions of a therapist. This is patently a contradiction. If it has appeared helpful to mothers and their children, this may be because the mothers become more comfortable in taking care of their children and not because it is therapy.

In an important sense, the therapist's functions are possible because they are different from those of a mother. The therapist enables the child to express directly and indirectly those feelings, thoughts, and fantasies which in the bosom of the family are usually expressed or maintained in a manner appropriate to the family setting and situation. To encourage a child to feel that the mother at appointed times will observe him and communicate with him differently than at other times is artificial and risky. Even more risky are the distorted assumptions that the theoretical and clinical training of a therapist requires no selection based on qualifications, no systematic education, and no definition of the scope and limitations of therapy.

Perhaps the most astounding implication of the program described is the omission of what can be termed the agreement between the therapist and the child and his parents in arranging the conditions that will make therapy possible. The implicit relationship of mother and child is not the same, nor should it be, as that of the therapist and his child patient. The former encourages an affectionate relationship based on the expectation that the child's developing needs and capacities and the mother's own development are mutually served by this relationship. In the child-therapist relationship, the aim is to help the child express and observe his inner attitudes and feelings so that he can resume a normal development in his family environment, strengthened by his self-understanding. The child who is treated by his parent as a patient may learn to distrust his parent, for he may experience the treatment as an unfair and artificial manipulation by an adult who is more knowledgeable and powerful than himself.

A child's conflicting attitudes toward his parents are unavoidable and necessary as part of growing up. In the process of maturing the child resolves and masters these conflicts, with or without the assistance of treatment. He stands to fail at resolution and mastery if the person toward whom his conflicting attitudes are chiefly directed, his mother, now becomes his therapist, invading the privacy a child usually has in a family and so complicating his conflict.

I also object to the restriction implied in the statement by Andronico and Guerney that the purpose of Project Headstart is to help disadvantaged children

"achieve intellectual levels nearer to other children." Actually, Headstart is designed to promote social, emotional, and physical as well as intellectual development.

And I would like to ask the authors some questions:

1. What is the "theory that nonprofessional persons may be successfully used as child psychotherapeutic aides in Headstart projects . . ."?

There are theoretical assumptions and formulations that could be invoked to examine this concept of child psychotherapeutic aides, but the authors make no attempt to state the theory or to suggest the limitations of such assumptions.

2. Since when is Rogerian therapy implied by the term child-centered play therapy?

Play therapy was actually introduced by child guidance clinics utilizing psychoanalytic theory, but no one theory of therapy can claim play therapy for its own. Since the project described was initiated with the idea of using persons trained in "filial therapy" as therapists, the errors, distortions, and ambiguities of what is considered "therapy" must have been conveyed to the trainees in this program.

3. What are the rules of the session that should be properly enforced? Why was the "therapy" administered for 30 minutes twice a week?

I believe the authors have confused the term "therapy" with "therapeutic." Many activities, including spontaneous individual play, formal education, and day-to-day experiences in the home, can have a healing or therapeutic influence. However, such divergent activities are not therapy. In fact, from the description in this article of what an aide did in helping one child, it appears that the authors are describing a process of education rather than one of therapy. At least, I hope they are.

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The authors of the case presentation, Michael P. Andronico and Bernard G. Guerney, Jr., will comment on some of the points made by the three critics in this commentary in the Readers' Exchange section of the next issue of CHILDREN—a section which is also open to comments by readers.

There are many positive roles that may usefully be assigned to nonprofessional persons in work with preschool children. A number of these have been explored during the past 3 years in the New Careers program at Howard University, with generally positive results.[1, 2, 3]

Such roles involve tasks that have customarily been performed by professional persons, for which professional persons are, in fact, "overtrained," tasks that a person of less education can, with appropriate training and supervision, carry out capably without loss of quality in the service. In such a situation the professional person serves as supervisor, trainer, and specialist. He is thus enabled to spend more of his time doing the kind of work for which his professional education prepared him and to amplify the impact of his professional education and experience.

I have been impressed with the "linkage" function that the neighborhood nonprofessional person can bring to the service situation, particularly in the disadvantaged community. The nonprofessional person is frequently much more familiar with the life styles in the local community, speaks the same language as the person being served, and represents for him a figure with whom it is much easier to identify.

However, for the benefit both of the program and the nonprofessional aide, any program using nonprofessional workers should provide them with the support of a continuous, structured training program, including on-the-job supervision, related educational experiences, and opportunities for advancement to higher levels of function and responsibility as experience is gained and skill developed. In the New Careers program at Howard, we have found that without these three elements, the early positive effects of enthusiasm, pride in involvement, and sense of novelty soon wear off, results become less clearly apparent, and the trainee-aide loses his motivation for the work and frequently drops out. It is never enough simply to define a new role, train a person once-and-for-all to perform it, pay him for his work, and leave it at that.

If the use of nonprofessional persons is to be fully effective, the definition of function and role for any type of nonprofessional helper must only be the first

step in a sequence of steps for developing or reorganizing a service program. If several different functions are defined for nonprofessional persons working at different levels and the roles of the professional persons are redefined and adjusted so that they can use their special skills more effectively, the result will be improved effectiveness of service.[4]

In general, the use of a nonprofessional person to provide ancillary services to a member of a children's group who has special needs, as in the case described by Andronico and Guerney, represents the kind of nonprofessional function that has been found to be very effective. However, the reader who is concerned with the applicability of this experiment to his own program should try to distinguish between the usefulness of the described nonprofessional "helping role" for children with special problems and needs and the theory and terminology of the specialized technique called "filial therapy" or "child-centered Rogerian play therapy."

As a psychiatrist, I have found that the child-centered Rogerian therapy is not applicable to all preschool children with emotional problems and disturbances and, in fact, may be quite the wrong approach to helping disturbed, disadvantaged preschool children from urban ghettos, whose major problems usually do not stem from repression but rather from adult abandonment, lack of concern, and lack of warm but firm direction. The case described by Andronico and Guerney should be used to stimulate thinking and experimentation with roles for aides in a Headstart-related therapeutic program rather than to provide a model of a technique to be followed. The very fact that an adult gives a disturbed child special attention and warmth may have much more to do with the outcome than the "nondirective" aspects of the "technique." This is an area requiring extensive, controlled study and followup as do many other currently accepted techniques of "psychotherapy" with children.

It is particularly important to consider whether the kind of activity described by Andronico and Guerney, although labeled and set apart as "therapy," might be much more effective if incorporated into the basic Headstart group program itself. There are various levels at which an aide could serve both preventive and corrective goals in working with children as part of the total program and contribute much to the basic conception of the educational process itself without being trapped into the psychotherapy paradigm.

I hope that the authors will continue their experimentation, perhaps in a direction more closely a part of the Headstart curriculum itself; and that for future reports they will prepare data both on followup of the children in their experiments and on comparison with control groups.

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The child . . . reacts to what he feels to exist in the outer world rather than to actual reality. His consequent unwillingness to accept restrictions, to renounce or to postpone wish fulfillment, his over- or underestimation of his own powers (feelings of grandeur, sense of inferiority)—all these constitute the young child's inherent social maladjustment which gives way gradually, as the sense of reality develops to a growing social adjustment.

Anna Freud,* "The Writings of Anna Freud; Volume IV, 1945–1956" *International Universities Press, New York, 1968.

NEW HOPE FOR BABIES of Rh NEGATIVE MOTHERS

JANE S. LIN-FU

Each year in the United States an estimated 200,000 to 300,000 pregnant women face the hazard of becoming sensitized to the Rh blood factor. While not all of these women become sensitized by such pregnancies, for the thousands who are so sensitized, the consequence is serious and often tragic. Once a woman becomes sensitized to the Rh factor, her future pregnancies are likely to result in infants with hemolytic disease, some of whom may be stillborn and some of whom may die shortly after birth or live with neurological defects. Hemolytic disease of the fetus and newborn has been occurring in one in every 150 to 200 pregnancies in the United States.

Recently, however, the development of the Rh immunoglobulin for the prevention of sensitization to the Rh factor has opened up an entirely new horizon for Rh negative women. To the couple involved, it means that they no longer need to face each pregnancy with fear and suspense or to prevent pregnancy because of the high risk of a tragic outcome. To the medical profession, it means a major medical advance, a leap from emphasis on treatment to emphasis on prevention.

For many years, hemolytic disease was a cause of repeated tragedy in affected families and an enigma to physicians. The etiology of the disease was unknown, the perinatal mortality associated with it was formidable, and among the surviving infants, neurological sequelae, including mental retardation, hearing loss, and cerebral palsy, were common.

After discovery of the Rh factor in 1940 and its role in the pathogenesis of the disease, treatment of affected infants became possible through exchange transfusion—that is, an almost complete change of the baby's blood shortly after birth. In the past few years, a procedure for intrauterine transfusion has been developed that can save some severely affected fetuses that would otherwise be stillborn. While these therapeutic measures have immensely improved the rate of survival of affected infants, Rh negative women have, until recently, still had to face each pregnancy with anxiety and uncertainty. Neonatal deaths have continued to occur in the severely affected infants, and a significant stillbirth rate has remained. Furthermore, the lifesaving measures themselves involve some risks.

The availability of Rh immunoglobulin promises a radical change. Hemolytic disease may in a generation's time become so rare as to be only of historical interest.

Rh factor

The Rh factor is a genetically determined substance present in the red blood cells of most people. Its name is derived from rhesus monkeys, which were used in the study that led to its discovery. Persons whose red blood cells possess this factor are referred to as Rh positive, and persons without it, as Rh negative. When introduced into the bloodstream of people who do not possess it, the Rh factor acts as an antigen

stimulating the person's immune system to produce anti-Rh antibodies. These anti-Rh antibodies have a special affinity for Rh positive cells, which they cause to be hemolyzed, or destroyed.

Marriage between an Rh negative woman and an Rh positive man is often described as Rh incompatible, as is pregnancy of an Rh negative woman with an Rh positive fetus. In an Rh incompatible mating, if the husband is homozygous for the Rh factor, that is, if he carries two Rh positive genes, all the offspring will be Rh positive, but if the husband is heterozygous, or carries only one Rh positive gene, the chances are that 50 percent of the offspring will be Rh positive and 50 percent Rh negative. An Rh negative woman married to an Rh positive man can therefore have either Rh positive or Rh negative children, depending on the zygosity of the husband. Only when she becomes pregnant with an Rh positive fetus is she faced with the potential danger of Rh sensitization. However, not all Rh negative women with Rh incompatible pregnancies become sensitized.

Among Caucasians, about 15 percent of the population is Rh negative; among Negroes, 5 to 7 percent; and among American Indians, Chinese, and Japanese, less than 1 percent. From these figures, it has been estimated that Rh incompatibility occurs in about 13 percent of marriages between Caucasians and about 5 percent of those between Negroes.

Hemolytic disease

During normal pregnancies, and particularly during labor and delivery, fetal red blood cells often find their way into the mother's blood circulation—a process known as fetal transplacental bleeding. In an Rh incompatible pregnancy, Rh positive fetal red blood cells that enter the mother's bloodstream may stimulate the mother's immune system to produce anti-Rh antibodies. These antibodies in turn cross the placenta and enter the fetus, destroying the fetal red blood cells. The result is hemolytic disease of the fetus and newborn.

Many blood factors can cause hemolytic disease but the Rh factor is most important, because of its frequency and the severity of the disease when it has been involved. Incompatibility in the ABO blood system (as when the mother's blood is type O and the fetus' blood is type A or B) also causes hemolytic disease in many infants, but most of these cases are mild and require no treatment. Very occasionally, rare blood factors are responsible for cases of hemolytic disease.

In hemolytic disease, destruction of the red blood cells generally begins in the fetus and continues in the newborn. The two salient clinical features, jaundice and anemia, are both the direct results of such hemolysis. Jaundice, a yellowish discoloration of the skin and whites of the eyes, occurs as blood cells are destroyed, releasing an excessive amount of bile pigments into the blood. Anemia is the result of red blood cell destruction.

Clinical manifestations of hemolytic disease vary. A fetus may be so severely affected that it dies in utero and is stillborn. Or the infant may be born prematurely with massive edema, or accumulation of fluids in his tissues, a condition called hydrops fetalis, and die shortly after birth of heart failure. Or the infant may become intensely jaundiced within minutes or hours after birth, a condition known as icterus gravis neonatorum. In less severely affected infants, congenital anemia may dominate the clinical picture. Enlargement of the liver and spleen is common among infants with hemolytic disease and represents an effort of the body to compensate for the excessive blood destruction by increasing the sites of blood formation.

Until treatment became available, neonatal mortality was 50 percent among infants born alive with hemolytic disease. Between 5 and 15 percent developed kernicterus, a form of brain damage caused by an excessive amount of bile pigment in the blood. About 70 percent of the infants with kernicterus die within 7 days of birth. Among those who survive, many have neurological handicaps. At one time kernicterus was responsible for 10 percent of all cases of cerebral palsy.

Early research

The forms of hemolytic disease of the fetus and newborn were first described in medical literature as separate entities. In 1932, Diamond and associates [1] observed that hydrops fetalis, icterus gravis neonatorum, and congenital anemia were different manifestations of the same fundamental disease process. Diamond and his research team coined the name erythroblastosis fetalis, based on the increased number of the immature red blood cells, or erythroblasts, found in blood and tissues of affected fetuses and infants. Recently, increasing numbers of physicians have been using the name hemolytic disease, because hemolysis is more typical of the disease than is erythroblastosis.

The Rh factor was discovered by Landsteiner and

Wiener in routine studies on antibodies in 1940.[2] They found that red blood cells of the rhesus monkey, when injected into rabbits, stimulated the production of an antibody that acted on the monkey's blood and caused it to clump or agglutinate. In laboratory tests the antibody affected red blood cells of most human beings in the same way. Red blood cells that could be agglutinated by serum containing the antibody were found to possess the antigen present in rhesus monkeys and were labeled Rh positive, while red blood cells that could not be agglutinated were termed Rh negative.

A year after the Rh factor was discovered, Levine and associates[3] suggested that erythroblastosis fetalis may be the result of hemolysis or destruction of the fetal red blood cells caused by maternal anti-Rh antibodies and provided statistical proof of this hypothesis. Shortly thereafter, it became clear that sensitization of an Rh negative woman may be caused not only by an Rh incompatible pregnancy but also by transfusion or intramuscular injection of Rh positive blood.

The discovery of the pathogenesis of hemolytic disease made it possible to develop methods of treatment and prevention. Typing of the blood for the Rh factor in both donor and recipient before blood transfusions represented the first systematic effort to prevent Rh sensitization of an Rh negative recipient. This procedure, adopted generally in 1947–48, has since become a routine procedure in most blood transfusion laboratories and has practically eliminated sensitization due to blood transfusions. Because the problem of Rh sensitization caused by an incompatible pregnancy seemed to defy solution, attention was concentrated on treatment of the affected infant.

In 1947, Diamond[4] and associates, introduced exchange transfusion to treat infants with hemolytic disease. This lifesaving technique removes the infant's own blood and replaces it with Rh negative blood, which is not vulnerable to destruction by maternal antibodies. Exchange transfusion has greatly reduced the number of deaths from hemolytic disease in newborn infants and has prevented kernicterus in most survivors. It is usually supplemented by induced early termination of pregnancy in Rh negative women to prevent stillbirth and limit the severity of the disease. Exchange transfusion is not without limitations, however; it rarely saves hydropic infants and it has no effect on stillbirths. Nevertheless, it was the only form of therapy that offered any hope for victims of hemolytic disease for many years. This technique and early termination of pregnancy together have reduced neonatal mortality among such infants from 50 percent to less than 5 percent.

In 1963, Liley[5] introduced the bold technique of fetal or intrauterine transfusion to save severely affected fetuses. This procedure, which requires a highly specialized medical team, is not yet widely available, however, and it is useful only in carefully selected cases. Even in skilled hands, intrauterine transfusion is associated with mortality of 5 percent for the fetus and very real risks for the pregnant woman. The overall incidence of stillbirth in hemolytic disease is generally considered to be between 15 and 20 percent; intrauterine transfusion could salvage between 30 and 50 percent of these infants.

Immunoglobulin

All these procedures are useful only after the fetus or infant has become affected by hemolytic disease. But the ultimate goal in the control of any disease is prevention. For hemolytic disease this goal is now within reach. The development of Rh immunoglobulin, a gamma globulin preparation with a high concentration of anti-Rh antibodies, makes it possible to prevent an Rh negative woman from becoming sensitized to the Rh factor during pregnancy and childbirth.

Many investigators contributed to the development of Rh immunoglobulin. Wiener[6] in 1948 suggested the theory of fetal transplacental bleeding to account for the sensitization of the pregnant woman. But it was not until 1957 that Kleihauer and associates[7] devised a rapid and accurate method to detect small amounts of fetal red blood cells in the maternal blood. The test is sensitive enough to detect as little as 0.1 milliliter of fetal blood in 5,000 milliliters of maternal blood.

Studies using the Kleihauer test have demonstrated that a few fetal red blood cells may be found in the pregnant woman's circulatory system as early as the first trimester of pregnancy, but that larger numbers are found in late pregnancy, during labor, and at delivery. Such studies have also demonstrated that

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the risk of maternal Rh sensitization is correlated with the amount of the fetal bleeding into the mother's circulatory system. In other words, the chance of a woman becoming sensitized to the Rh factor increases as the fetal cell count of the pregnant woman increases. This observation explains why Rh sensitization occurs more frequently following traumatic or manipulative procedures resulting in massive fetal hemorrhage during labor and delivery.

On the basis of these findings, research workers reasoned that Rh sensitization of an Rh negative woman can be prevented by eliminating the fetal red blood cells from her body before they have a chance to stimulate production of anti-Rh antibodies. But the questions remained: When should this be done? And how? Sensitization only very rarely occurs during the first Rh positive pregnancy, despite the fact that fetal transplacental bleeding during pregnancy allows ample time for antibodies to be formed. Antibodies are seldom demonstrable in a woman's blood within a 2-month period following the delivery of her first Rh positive infant. This long period of latency between the introduction of fetal red blood cells into the maternal circulation and the appearance of antibodies led to speculation that the raised levels of certain hormones during pregnancy may render a woman relatively unresponsive to sensitization and that fetal red blood cells in the mother's circulation become an effective antigen only after delivery when the mother's immune system is no longer under suppression. If such were the case, research workers reasoned, measures to eliminate the fetal red blood cells from the maternal circulation could be delayed until after delivery.

Two studies

In 1960, two independent groups of investigators began to study the possibility of preventing Rh sensitization. In New York City, Freda, Gorman, and Pollack [8] based their work on the immunological principle that passive immunity can block active immunity. When this principle is applied to the Rh phenomenon, it means that anti-Rh antibodies injected into an Rh negative woman should prevent her body from making anti-Rh antibodies when she is challenged with Rh positive red blood cells from her fetus. The investigators gave intramuscular injections of Rh immunoglobulin to a group of Rh negative male volunteers. The immunoglobulin prevented formation of anti-Rh antibodies in these men when they were later injected with Rh positive blood. In a control group of Rh negative men who did not receive Rh immunoglobulin but were injected with Rh positive blood, several developed anti-Rh antibodies.

At the same time, Finn, Clarke, and associates,[9] in Liverpool, England, started out from a different premise. It is well known that ABO-incompatible pregnancy often protects Rh negative pregnant women from Rh sensitization. The English workers reasoned that, if the woman's anti-A and anti-B antibodies destroy the fetal red blood cells before they stimulate the production of anti-Rh antibodies, the protective action of the anti-A and anti-B antibodies in the pregnant woman's blood can be mimicked by anti-Rh antibodies. In a carefully controlled study, a group of Rh negative men were given intravenous injections of plasma containing a high concentration of anti-Rh antibodies and Rh positive red blood cells. These men did not develop anti-Rh antibodies, but the men in a control group did.

Since these experiments were carried out, clinical trials of Rh immunoglobulin have been conducted among Rh negative women in 43 medical centers in various parts of the world.[10] To date, more than 3,000 pregnant Rh negative women have participated in the clinical studies. Results of two separate studies involving a total of 1,807 women are now available. None of the women showed anti-Rh antibodies in their blood prior to and at the time of delivery. The infants being born were all Rh positive, ABO compatible with the mother, and in laboratory tests showed no maternal anti-Rh antibodies attached to their red blood cells. The women in each study were divided into an experimental group and a control group. All women in the experimental group were given one intramuscular injection of Rh immunoglobulin within 72 hours after delivery.

The two studies differed only in dosage. In the first study, 300 women were given an injection of 5 milliliters of immunoglobulin; 227 women served as controls. None of the treated group became sensitized in the 6 months after delivery, but 19 of the women in the control group did. In the second study, 781 women were given 1 milliliter of Rh immunoglobulin after delivery; 499 women served as controls. When studied 6 months later, one woman in the treated group and 32 women in the control group had become sensitized.

Because pregnant women sometimes become sensitized to the Rh factor without developing demonstrable antibodies, a subsequent birth of an unaffected Rh positive infant will serve as ultimate proof that

the women in the treated groups did not become sensitized. Followup reports have been made on 145 women from the two studies who have had a subsequent Rh positive pregnancy. Among 82 treated women, 81 delivered unaffected infants. Seven of the 63 women in the control group delivered infants affected with hemolytic disease.

The results clearly indicate that a single intramuscular injection of at least 1 milliliter of Rh immunoglobulin given within 72 hours after delivery of an Rh positive infant will effectively prevent Rh sensitization of the Rh negative woman under normal circumstances.

Implications

Clinical trials of Rh immunoglobulin have indicated that side effects are infrequent and—when they do occur—usually mild. Since Rh immunoglobulin provides definite protection against Rh sensitization and since at present the state of sensitization is irreversible, all women who face the potential danger of Rh sensitization should be offered this effective measure. For all unsensitized Rh negative women who give birth to Rh positive infants, the injection should be repeated after every Rh positive pregnancy within 72 hours of delivery.

Admittedly, the adoption of such a routine procedure would mean that many women would be given Rh immunoglobulin unnecessarily. However, there is no way today of predicting which Rh negative women will become sensitized after delivery of an Rh positive child. One can only speculate in terms of high or low risk. It, therefore, seems advisable that Rh immunoglobulin be given to everyone who is confronted with the potential hazard of becoming sensitized to the Rh blood factor.

The use of Rh immunoglobulin is a preventive measure. It is not indicated for women who are already sensitized to the Rh factor. Moreover, Rh immunoglobulin is not indicated for Rh negative women who have an Rh compatible pregnancy, for they do not face the risk of Rh sensitization. More important, Rh immunoglobulin should not be given to anyone during pregnancy because it can cross the placenta and damage the fetus.

THE PREVENTION of Rh sensitization by using Rh immunoglobulin represents a new approach to an age-old problem. Now a woman no longer need wait for sensitization to occur, for hemolytic and other pathological processes to be initiated, or for the fetus or infant to be damaged before taking steps to protect her infant. A simple procedure can avert a disastrous chain of events. If this procedure is systematically applied to all mothers who are faced with the possibility of Rh sensitization, the incidence of hemolytic disease of the fetus and newborn can be reduced nearly to a vanishing point, once the present generation of sensitized women has passed the childbearing age.

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A SOCIAL WORK MISSION TO HIPPIELAND

DAVID CRYSTAL

IRWIN H. GOLD

In the summer of 1967, the Jewish community of San Francisco offered the service of a social work "participant-observer" to the young people who were pouring into the Haight-Ashbury section of the city, attracted by its fame as the Mecca of the Hippies. This service has since been terminated because of the changed character of the area. However, it taught the sponsoring organizations a great deal about the value and limitations of an individualized service in helping young people whose alienation from society derives in large part from the character of society itself.

The Haight-Ashbury section of the city where most of the Hippies were concentrated is a neighborhood of some 45 square blocks with a normal population of 8,000 to 9,000 people. Before 1964, when many young newcomers began arriving, it could be characterized as a relatively stable neighborhood inhabited by families of low-middle income.

Beginning in 1964, former "beatniks," graduates from the Berkeley "freedom movement," former civil rights workers, *avant garde* intellectuals, and other young people who were disengaging themselves from a more active role in society began to move into the area. By the winter and early spring of 1967, some 5,000 Hippies had swelled its population. Other Hippies were living in contiguous neighborhoods.

The Hippie movement was, and still is, characterized by the use of drugs (especially LSD and marihuana), the espousal of free sex and elimination of the "double" standard, and personal philosophies based on love and sharing with the "tribe." Groups of young people shared living quarters and food, perhaps as a manifestation of their philosophy, perhaps, too, as a result of the limited living space available and the general meagerness of their incomes. Intellectualism declined in prestige as "action," "sensing," "meditation," and "Eastern mystic experience" climbed in the hierarchy of values.

Even at the height of the Hippie invasion the majority of the inhabitants of the Haight-Ashbury district still consisted of the oldtime residents, members of the "straight" community who customarily had had an accepting attitude toward newcomers but who tended to become antagonistic to the young inmigrants as the crowding increased, rents went up, and the unconventional behavior became more visible. Most of the newcomers were unemployed or employed only part time. Some were artists, writers, merchants of hip ornaments or peddlers of hip publications. Others panhandled and many sold drugs. The newcomers also included a few aggressive young people of the "Hell's Angels" type who apparently came to exploit or intimidate the Hippies, but found themselves accepted. The few isolated incidents of violence that occurred were probably inevitable in this strange mélange of cultures.

Concern and action

In the spring of 1967, the Hippies already living in the area were heralding the coming "summer of love," and the city newspapers and television stations were predicting the in-migration of as many as 200,000 young people from all parts of the United States and Europe. The social agencies of San Francisco were acutely aware of the threat implicit in such sudden mass in-migration. A committee was formed representative not only of voluntary and pub-

Based on a paper presented at the 1968 forum of the National Conference on Social Welfare.

lic social and health agencies but also of Hippie organizations. From the committee's meetings emerged a plan to locate and house runaways under 16 years of age. As a result, a local church provided and staffed a residence, called Huckleberry House, to shelter and serve young runaways attracted to San Francisco by the movement. The cooperation of the police department made possible a form of service that, at least for a while, could bypass arrest in working toward the return of the young people to their homes.

Other organizations also offered services to the Hippies, especially casework agencies, colleges, and churches; but generally these services were provided only on an occasional or emergency basis.

The Hippies themselves also established services. These included the Switchboard, which offered Hippies a 24-hour referral and information service and an employment service, both organized and operated by a community-conscious group called the "Diggers."

The organized Jewish clergy of the Bay Area expressed concern about the proportion of Jewish young people among the Hippies of Haight-Ashbury, rumored to be as high as 40 percent. A special Passover Seder held in the area attracted 80 young men and women. Some people suggested that this response reflected "an underlying yearning among the young Hippies for renewal of communication between family and community." Others suggested that the young people were simply hungry.

There were reports of rampant illness, malnutrition, and unsanitary living conditions among the Hippies, including the Jewish youngsters. In addition, Jewish agencies and temples were being besieged by inquiries of anguished parents from all over the country whose children had left home, drawn magnetically to the new frontier. Because of the general concern and the need to find out more about the situation, the Jewish Welfare Federation decided to sponsor a special Haight-Ashbury project under the joint auspices of the United Jewish Community Centers and the Jewish Family Service Agency. The project had the following tentative objectives:

1. To assess the extent of Jewish participation in the Haight-Ashbury Hippie movement.

2. To cooperate with the service programs in the area that were attempting to meet the urgent needs of individual young people for medical, psychological, and economic assistance.

3. To report needs pertinent to immediate and long-term planning to an advisory citizens committee set up by the Jewish Welfare Federation.

4. To receive and refine impressions of the factors that disposed young people to become Hippies.

5. To encourage young people to return to the accepted styles of community life.

Impressions and misgivings

In committing itself to this project, the planning body expressed some misgivings, based largely on the following impressions of the Hippie movement:

1. The Hippies' characteristic detachment from struggle and from involvement with the "straight" world, their emphasis on easy, accepting relationships with one another, and the absence among them of overt, aggressive behavior might conceal a deep, covert hostility to society, which would render them inaccessible to any kind of relationship with any agency of the so-called "establishment."

2. Because the theme of the Hippie movement was "tune in, turn on, and drop out," the movement seemed to magnetize toward it diverse kinds of young people with one common attribute—a passive rejection of all the mores and values of our culture. Those who were attracted to the movement seemed to be signifying a rejection of all active social protest and to be saying in effect "what's the use?" (Protest against the war in Vietnam provided the one exception to this refusal to confront society.)

3. The unconventional dress and behavior characteristic of the Hippies suggested a deep nostalgia for earlier times, presumed to be simpler, more idyllic, and more conducive to clearly defined social and personal relationships. The long hair and beads, the dress styles borrowed from the past, such as the tunic and sandals of early Christian-Roman times, suggested, as one anthropologist put it, "the search for a lost childhood." Other evidence that regressive withdrawal tendencies were pervasive among these young people could be found in their predilection for discussing mystical philosophy and their search for "mind-expanding experiences" either vicariously through the arts or directly through the use of drugs.

4. Individual Hippies as well as their organized groups asked for nothing, but accepted whatever was made available to them. In other words, there seemed to be a pronounced social trait among these young

people of deep, passive dependency. The social work members of the project committee had often dealt with this trait in individual clients and knew its clinical manifestations and causes. But what did it mean as a generalized social trait?

5. The Hippie speech patterns and new vocabulary as well as the style of their arts and crafts revealed a consistent use of vague, abstract, symbolic forms as substitutes for clear, precise definition in communication. Here again seemed to be evidence of a tendency to turn away and look inward and backward. Was this tendency among the Hippies an early symptom of a regressive reaction to cumulative stress on the part of society itself? If so, did the movement tend to attract the more maladjusted members of our young population? Where did social movement and personal pathology diverge?

The beginning

In spite of these impressions, the committee went ahead with its plans to employ a social worker to explore Hippieland as a participant-observer. It chose a young woman who identified positively with the Hippie movement, but who was "still committed to the value-system of the mainstream of American life." Youthful, sensitive, intelligent, empathic, she had already worked in the Haight-Ashbury community as a volunteer. To indicate her role as a liaison person from the "establishment" the committee provided her with an office in the community.

One of the first things the social worker did was to send a letter to all Jewish family service agencies in the United States and Canada and to all synagogues and temples in the United States informing them of the establishment of her office and inviting inquiries about individual young people. She also quickly made herself known to the Hippie organizations in the Haight-Ashbury district as well as to the organized committee of social agencies serving the area. She put up a sign on the office door, "The Jewish Welfare Federation loves you." (Later she changed this to "Bet Shalvah"—House of Peace and Tranquility—in accordance with the tendency in the district to create a mystical, romantic aura around all organization forms.)

And then things began to happen!

Irate contributors to Jewish philanthropy began telephoning the offices of the Jewish Family Service Agency and the United Jewish Community Centers to complain that heavily bearded, strangely garbed men and barefooted, oddly madeup girls had been seen going in and out of an office on which the name Jewish Welfare was clearly marked, and from which emanated the sounds of guitar music, a folk-rock band, and other unwelcome noises. At the same time the social worker in the new Haight-Ashbury office was receiving long distance calls—some of them from as far away as Montreal and Tallahassee—with anxious requests for her to search for a son or daughter who had presumably headed for San Francisco, to call back as soon as the young person was found, and to see that food and shelter were provided.

Meanwhile the city was becoming alarmed about the prevalence of illness among the Hippies—especially hepatitis, venereal disease, and respiratory infections. The crowded Hippie "pads" threatened to become contagion centers unless the community agencies and the city provided special help. The newspapers dramatized the danger, and the whole community seemed to polarize into those citizens who felt emergency relief measures should be immediately established and those who would deny any help, hoping thereby to stop the tide of in-migration and, in fact, to force the outsiders to move away.

Thus in the early weeks of the project, the social worker became absorbed in working with representatives of other agencies to find ways of meeting the health crisis. Consideration was given to establishing a small convalescent center, but this failed to materialize. The worker then supported efforts to achieve extension of existing medical facilities and establishment of a clinic within the Haight-Ashbury district.

So much concern was aroused in the community by these efforts and by the alarm expressed by the San Francisco Department of Health that a number of physicians, psychiatrists, social workers, and nurses formed their own Haight-Ashbury medical clinic, contributing their professional services on a volunteer basis. In addition, a hospital affiliated with the Jewish Welfare Federation, after some persuasion from the project social worker, extended its clinic facilities to the young people suffering from infectious diseases and established special procedures for expediting their treatment. These services did not prove adequate for meeting all the health needs in the Haight-Ashbury district, but their existence did arrest a serious health problem.

Throughout the health crisis, the young residents of the Haight-Ashbury area did not themselves demand additional health services. However, some of the Hippies, especially the Diggers, quietly provided the sick with concrete help in the form of food, clothing, and money, which they received from con-

cerned people in the community at large, although they did not conduct any formal solicitation for contributions.

Service to individuals

The Jewish Welfare Federation had hoped that its project in Haight-Ashbury could steer those youngsters whose emotional problems had driven them to join the Hippie movement to the agencies that could help them confront and deal with their problems. However, the project's social worker made very few referrals to such agencies. This was not because of any lack in her ability to establish contact with young people in trouble. On the contrary, she became adept at communicating with the young societal dropouts and seemed to be well accepted in Hippieland as a participant-observer. She did locate some runaways and expedited their return home. But, in general, she could not serve as a bridge back to the "straight" community.

By and large, the young people in need could willingly take the concrete services brought to them—meals, clothing, money, medication. They received any form of relief from immediate pressure with appropriate feeling, but always in terms of the present without reference to past or future. Their dialogue, analysis, and planning stemmed from the current "scene," and the current scene did not allow for consideration of the future. They were not interested in resolving a problem by changing their present pattern of adjustment.

In her person-to-person interviews, the social worker rarely found it possible to use an immediate need as a basis for the kind of deeper individual probing that would result in a referral to a counseling and psychiatric agency. Even when she did manage to make a referral, the resultant service usually only covered the crisis such as the immediate consequences of a "bad trip" (a toxic reaction to drugs) or another health emergency. Once a crisis was relieved, the agency dealing with it had great difficulty in engaging the young person in a consideration of its causes.

In a few cases, however, a deeper involvement of the young client was achieved. These cases nearly all involved young people who could not find emotional support in their affiliation to the Hippie movement. For them their Hippie experience was but another phase in a long history of personal maladjustment and had not brought them the gratification they had sought. In a sense, they were deviates from the deviant culture itself and, hence, were more amenable to continuing contact. As such they gave little promise of achieving full rehabilitation. Some of these young people continued in casework treatment on a supportive basis for a long time and moved gradually away from the Hippie anchorage. However, they did not really become integrated into the "straight" world but remained on the periphery.

The social worker referred several youthful runaways under 16 to Huckleberry House for immediate haven and a marshalling of the necessary counseling services. She found that in some of these youngsters the magnet of Hippieland had reinforced an already existing adolescent conflict and the runaway experience had opened up a rich opportunity for exposing the past resistance to seeking help in resolving a long-standing family problem.

The social worker also dealt with a number of young women who had been trapped into unwanted pregnancies by their yearning for acceptance and love. Usually they were very willing to accept the community services established for unmarried mothers. In many of these cases the pregnancy brought to the surface the emotional conflicts for which the Hippie movement had served as a foil.

The social worker also met a number of deeply disturbed young people for whom the camaraderie and outer symbols and rituals of the Hippie movement seemed a materialization of their fantasy life. These young people were usually excessively dependent persons, whose need to cling to and exploit others and lack of any sense of reciprocal obligation seemed to represent a displacement to friends and "pads" of emotional grievances against family and home. The project worker referred a number of such young people to the family service agencies, but the agencies had only limited success in helping them arrest their repetitive pattern of flight, clinging, and rejection. In basic psychosocial disturbance, these young people resembled many of the people ordinarily seen by family service agencies except that their invariable use of drugs complicated the treatment process.

Some observations

For the most part, the social worker concerned herself with observing the character of the Hippie group and the kind of values and cultural change it represented. She found that the Hippies did not use social agency help to an appreciable degree and that, with a few exceptions, they did not disrupt or interfere with community life. She confirmed reports that a large proportion of the Hippies consisted of Jewish

David Crystal, left, has been director of the Jewish Family Service Agency in San Francisco for 10 years. He received his doctorate in social welfare from Columbia University in 1957. **Irwin H. Gold**, executive director of the United Jewish Community Centers in San Francisco, received his master's degree in social work from the University of Pittsburgh.

young people from middle-class backgrounds. This fact could perhaps be expected in a movement of middle-class youth in revolt against middle class standards, for the Jewish community in America is predominantly middle class, and Jewish young people have always participated in the major drives for social change.

The social worker also found that most of the Hippies in the Haight-Ashbury section were between the ages of 14 and 24, the majority being between 17 and 22. These ages encompass the period of life that has been called "the age of emancipation"—a stage when young people are apt to rebel against all forms of parental and societal authority in their attempt to achieve what Erikson has called a "sense of identity," [1] that is, a sense of integrity and of firmness of self and outlook.

Thus, for many young people the Hippie movement may serve as a special ground for the expression of normal growth. It features the distortions of our adult value system. Indeed the Hippie orientation mirrors in reverse those features of society that handicap the achievement of identity and integrity. Instead of conforming with clocklike efficiency and conformity, the Hippie tends to be extremely casual, individualistic, and nonconformist; instead of emphasizing duty and obligation, he emphasizes "freedom" to respond to impulse and desire; instead of using aggression and power to get his way (individually or politically), he uses love and consent and takes a laissez-faire policy with respect to others.

No one really knows how many Hippies came to San Francisco in the summer of 1967. Estimates range from 10,000 to 100,000. Most of the newcomers, however, stayed only for a short time, some only for a week or two, and as the summer progressed, it became apparent that more young people were leaving the area than were coming in. There were probably not more than 7,000 Hippies living in the Haight-Ashbury section at any one time, not counting the several hundred who were coming and going each day. By August this figure was probably cut in half; by October it was probably no more than 1,200.

In the summer of 1968, there was a sudden resurgence of a Hippie-like migration into the Haight-Ashbury area, but this was short lived. Today a hard-core group of Hippies remains, but on the whole the Hippie movement seems to have lost its uniqueness and cohesion as young people have diverted their energies to other methods of protest.

Most of the facilities set up for or by the Hippies in the Haight-Ashbury section in 1967 are now closed, including Huckleberry House and the special medical clinic. The Jewish Welfare Federation withdrew its social worker from the area in December 1967, leaving to the Jewish Family Service Agency the responsibility for providing emergency casework service to young people in the area and for dealing with inquiries about runaways, which had dried up to a trickle. The social worker's observations, however, convinced the sponsoring agencies that the problems of today's alienated youth are larger than the individual and stem from the failure of the institutions of society. A committee of the Jewish Welfare Federation, therefore, has since been addressing itself to ways the existing Jewish institutions might be modified to serve young people more effectively.

We believe that the Hippie movement was not entirely a transient, meaningless fad. Its widespread appearance conveyed a message that could not be hidden by adult response with guilt-provoked righteous indignation: young people have seen through the hypocrisy of a society where vaunted idealism glorifies the spirit of the individual and rampant materialism degrades it.

Every generation has its Bohemian element with distinctive characteristics reflecting the particular imbalances of the times and carrying a symbolic message to the whole society. Today's young Bohemians, the Hippies, represent a protest against depersonalization, computerized thinking and doing, and above all, the distortion between people's daily living and their alleged ethics and values.

As a deviation from social norms, the Hippie movement appears to be regressive, infantile, and sick. But is the norm normal? Or is today's idea of a "successful adult" itself a distortion of a truly human, integrated personality?

[1] Erikson, E. H.: Identity: youth and crisis. W. W. Norton & Co., New York. 1968.

Some observations from the first Conference of Ministers Responsible for Social Welfare . . .

DEVELOPING MANPOWER FOR THE WORLD'S SOCIAL WELFARE NEEDS

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How to get and train the manpower for carrying out the social welfare programs necessary for national development occupied a major portion of attention at the first Conference of Ministers of Social Welfare, convened by Secretary General U Thant at United Nations Headquarters, September 2–3, 1968, at the request of the United Nations Economic and Social Council. Delegations from 87 countries participated officially in the conference; and delegations from 9 other countries, 7 U.N. affiliated organizations, and 18 nongovernmental international organizations attended as observers.

In addition to manpower needs, the agenda of the conference focused attention on the place of social welfare programs in national development, government responsibility for social welfare, and international cooperation for social welfare. While each of these subjects received detailed attention in one of the four Technical Commissions in which the conference divided, their interdependence was made abundantly clear in the debates in the Commissions and the plenary sessions as well as in the U.N. technical papers and country position papers prepared for the conference in advance.

An underlying assumption of the conference, explicitly stated by the chief of the U.S. delegation[1] as well as by representatives from other countries, was that the development of nations depends on the well-being of the human beings within them, especially children and their families, and that, therefore, national planning must contain a large element of social welfare planning, focused sharply on the development of programs to strengthen family life. Nearly all the delegations testified to a common obstacle in reaching this objective—an extreme shortage in persons trained to plan, run, and man the necessary social welfare programs. Thus many suggestions emerged for accelerating the preparation of people to participate in all levels of efforts for social welfare—policymaking, research, administration, supervision, direct service, and volunteer work.

The U.N. Secretariat had prepared a working paper, "Meeting Manpower Needs for Social Welfare." It underscored the need for governments to take responsibility for planning to build up the quantity and quality of manpower for social welfare programs; urged that such planning be incorporated in overall national plans for professional education and vocational training; and emphasized the need to train for interdisciplinary teamwork and the development of leadership for policymaking. It also pointed to the need for each country to develop a core social welfare curriculum closely related to the country's customs and socioeconomic conditions; and urged that international cooperation be focused on "indigenous training programs" and on strengthening regional facilities for advanced training.

A comprehensive policy

The emphasis on governmental responsibility for developing a comprehensive manpower policy for social welfare was reiterated in the Commission on Manpower, which I attended as an official observer. In the deliberations of this Commission, many of the delegates stressed the importance of training leaders in the social welfare field to exert leadership in overall government planning and operations. They pointed out that because national social and economic policies affect people's lives, leaders in the social welfare field could make an important contribution to national development if they were trained to play a major role in policy development and in the development of legislation. Delegates from Israel, the Philippines, and Peru especially stressed this point.

The members of the Commission on Manpower also gave a great deal of attention to the need for training indigenous workers for social welfare programs—that is, training persons from the areas to be served to carry out the needed services. It was repeatedly stressed that social welfare workers should receive their basic training within their own countries so that their

training would be geared to the countries' specific needs and an understanding of the customs and psychology of their people. Along with this emphasis went an emphasis on developing materials within each country drawn from experiences within that country.

On the whole, the discussions indicated that the current trend in most countries is to prepare "generalists" for social welfare services, using the schools of social work or other formal training facilities for this purpose and relying on the service agencies to provide through inservice training what specialized training the workers might need to carry out the agency's function.

Levels of personnel

Considerable interest was evinced, however, in identifying various levels of social welfare personnel according to the tasks performed and defining a specific recruitment and training program for workers at each level. This point was stressed by the delegate from India, who said that without such a plan the manpower resources for social welfare would be wasted. The delegates from the Philippines and from the United Arab Republic spoke for the need to include a training program for volunteers in any manpower training plan.

Recruiting as such did not receive the same proportion of attention as training, but when the subject did come up it was inevitably tied in with the need to upgrade salaries for all levels of social welfare personnel—a particularly serious problem in the countries with extremely limited financial resources. The delegate from Indonesia urged the allocation of a portion of each country's national budget for training and research in manpower needs, including manpower for social welfare programs.

"Social welfare" within this conference may have had different meanings to different delegations, but on the whole the definition seemed to be broad enough to encompass any activity focused specifically on preventing or dealing with the problems that disrupt people's lives and, therefore, requiring a knowledge of people's needs and ways of meeting them. This core of knowledge many delegates seemed to see as essential for workers at all levels of service, with additional training superimposed according to discipline, specialty, and degree of responsibility to be assumed.

Thus, the delegate from the Union of Soviet Socialist Republics stressed the need for training health workers, as well as the need for special courses for physicians and teachers who become involved in social welfare activities. The Mexican delegate stressed the need for involving health educators and agricultural advisers in social welfare training sessions. The delegates from Malaysia and the U.A.R. stressed the need for multipurpose workers. The Israeli delegate stressed the need for training rehabilitation workers. The Jordanian delegate stressed the need for training geared specifically to the refugee problem.

The political structure and degree of economic development of the country, of course, affected the particular emphases of the delegations. The delegate from the U.S.S.R., for example, recommended that all training be done at state expense. The Australian delegate stressed the importance of voluntary agencies participating in a country's development of a manpower plan. Several delegates, including those from Saudi Arabia, the U.A.R., and Indonesia spoke for international cooperation to help countries with their training problems through the establishment of special regional training facilities and through regional or subregional seminars.

International help in training persons for service in the social welfare field was called for especially in relation to higher level workers—the policy makers, planners, and administrators. Some delegates recommended exchange programs, but for such decision makers only. Greater stress, however, was put on the provision of technical assistance to countries to help them build up their own training facilities and programs. Regional and subregional cooperation for training was particularly stressed, the feeling seeming to be that the nations within a region were likely to have similar problems and to understand each others' needs more than nations in disparate parts of the world.

U.S. participation

The United States had no voting delegate in the Manpower Commission, but its two official observers at the Commission meetings were given an opportunity to express the U.S. point of view. We strongly supported the recommendations in the Secretariat's working paper on manpower for the assumption by government of responsibility for the sound development of social welfare services; put a high priority on rapid expansion and improvement of education for social welfare at a succession of levels, including formal training programs for auxiliary workers, graduate education for professional workers, and continuing inservice training for all levels of personnel; recommended reorientation of social welfare education to impart skills for helping people to work cooperatively to improve living conditions and make social institutions more relevant to current needs; stressed the importance of the wider use of nonprofessional workers and volunteers; urged the development of national and regional plans of study, conferences, and exchange of faculties and material in the social welfare field; urged that the field of social welfare be represented on the central planning bodies concerned with overall manpower needs; stressed the importance of data collection and analysis on a national or regional basis to assess manpower needs for the social welfare services and the kinds of manpower suitable for carrying out social welfare tasks, and urged that the United Nations provide technical assistance in this regard; and supported the U.N.'s emphasis on concentrating international cooperation on building up indigenous training facilities and teaching materials within each country and establishing regional facilities for advanced training.

Universities' role

We pointed to the need for professional education for social welfare at the master's level to provide the necessary leadership, and made a clear distinction between training workers for any level of social welfare service and training technical assistants in the fields of health, economic development, and agriculture—a distinction not always made clear by other delegates.

Other delegations also stressed the role of universities in promoting and protecting the quality of social welfare manpower. The delegate from Peru, for example, emphasized the university's role in developing research in manpower needs and educational methods as well as for developing resources for training. The delegate from Israel

pointed to the need to protect the quality of manpower at all levels of service and suggested that nations establish registration and licensing systems for persons trained for social welfare service.

Recommendations

In its report to the plenary session, the Commission on Manpower recommended the adoption by governments of a central manpower system with social welfare as a component, the establishment of training programs for various levels of social work personnel, the provision of better salaries and working conditions to increase the prestige of occupations in the social welfare field, the involvement of experts from the field of social welfare in high governmental planning, the development of training materials within the areas in which they are to be used, the establishment of training facilities within each country, and the international development of regional and subregional training and research centers.

After the discussions of the Commissions' reports, the conference adopted 29 recommendations.[2] These were forwarded to the Economic and Social Council with the request that they be submitted to the twenty-third session of the United Nations General Assembly. Five of these recommendations concern manpower needs for social welfare. In brief, they urge that—

- The provision of qualified personnel for all levels of social welfare service be made a major concern of governments.
- Governments assess the particular requirements for such personnel in their countries in relation to total manpower needs, with attention to both rural and urban areas.
- Special emphasis and international help be given to the preparation of leadership for planning and implementing social welfare programs adapted to the specific conditions of each country.
- Emphasis in social welfare training programs be put on the preparation of indigenous teachers responsive to local conditions, and on the production of training materials drawn from the experience in the country.
- Training programs be geared to facilitating the flexible use of all levels of social welfare manpower and preparing workers for teamwork with members of related occupations; curricula be periodically reviewed; and regional cooperation in new training experiments be encouraged.

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[1] Cohen, W.: The developmental approach to social challenges. *Children*, November–December 1968.

[2] United Nations, Economic and Social Council: Report of the International Conference of Ministers Responsible for Social Welfare, October 7, 1968. E/4590.

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guides and reports

EDUCATION AS THERAPY: suggestions for work with neurologically impaired children. Ruth Mallison. Special Child Publications, 4535 Union Bay Place, NE., Seattle, Wash. 98105. 1968. 166 pp. $3.50.

Describes methods for use by special educators in evaluating and helping children with neurologically based learning difficulties.

CLASS AND ETHNIC DIFFERENCES IN THE RESPONSIVENESS OF PRESCHOOL CHILDREN TO COGNITIVE DEMANDS. Margaret E. Hertzig, Herbert G. Birch, Alexander Thomas, and Olga Aran Mendez. Society for Research in Child Development, The University of Chicago Press, 5750 Ellis Ave., Chicago, Ill. 60637. 1968. 69 pp. $3.

Compares the behavior in response to demands made in intellectual testing of 3-year-old children of Puerto Rican unskilled and semiskilled workers and 3-year-old children of business and professional persons born on the U.S. mainland.

MULTIPLY-IMPAIRED BLIND CHILDREN: a national problem. Milton D. Graham. 1968. 82 pp. $1.50.

NO TIME TO LOSE: a symposium. Pauline M. Moor. 1968. 53 pp. $1.35. American Foundation for the Blind, 15 W. 16th St., New York, N.Y. 10011.

The first reports the results of a 1966 survey on multiply-impaired blind children in the United States; the second, a 1964 seminar on methods of teaching such children.

HOUSING FOR EARLY CHILDHOOD EDUCATION: centers for growing and learning. Association for Childhood Education International, 3615 Wisconsin Ave., NW., Washington, D.C. 20016. 1968. 84 pp. $1.50.

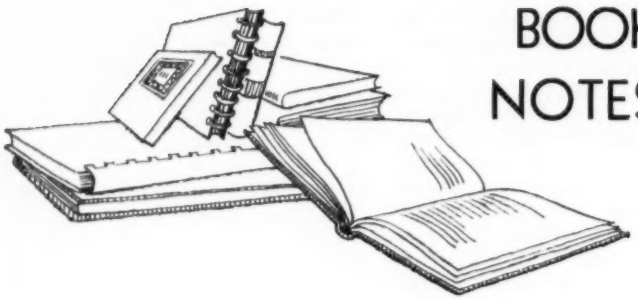
Offers guidelines for designing nursery schools and kindergartens with indoor and outdoor facilities, space, equipment, and materials adequate for maximum growth and learning in preschool children.

BUILDING TOGETHER: a selected reading list. American Library Association for United Community Funds and Councils of America, Inc., 345 E. 46th St., New York, N.Y. 10017. Revised 1968. 30 pp. 50 cents. Special rates for orders of more than 10 copies.

Lists 207 titles of books for boys and girls that illustrate some phase of social responsibility.

AN OVERVIEW OF UNDERGRADUATE EDUCATION IN SOCIAL WELFARE: past issues, current developments, and future potentials. Arnulf M. Pins. Council on Social Work Education, 345 E. 46th St., New York, N.Y. 10017. 1968. 23 pp. $1.

Examines the objectives and curriculum of undergraduate programs in social welfare and the role of these programs in meeting social work manpower needs.



BOOK NOTES

EARLY CHILD CARE: the new perspectives. Edited by Laura L. Dittmann. Foreword by Caroline A. Chandler and Anne DeHuff Peters. Epilogue by Reginald S. Lourie, Atherton Press, New York. 1968. 385 pp. $8.95.

A result of a series of four conferences of research psychologists, pediatricians, psychiatrists, and other specialists in child development, this book has what the editor calls a "double focus": (1) to identify what is known about the developmental needs of children under 3; and (2) to present ways of applying this knowledge in child-care programs—those that substitute for the child's own family, those that supplement the care the child receives at home, and those that concentrate on helping the family itself improve its quality of care. Its 14 papers (by 13 authors) are presented in four sections: I. A New Look at the Young Child: Development and Individuality; II. Translating Child Care Goals into Procedural Terms; III. Contemporary Programs and Strategies; and IV. New Research in the Prevention of Culturally Determined Retardation.

Part I contains papers discussing the development of the child in each of his first 3 years, the way the factors in the child's environment affect and are affected by the child, and how these environmental factors can be manipulated by the caretaker to affect the child's development.

Part II contains papers discussing ways of assessing the needs of specific children and the responses to be expected from manipulating the environment in specific ways.

The papers in part III describe and discuss the implication for program planning of patterns of child care among the poor in this country and group care programs for infants and young children in other countries.

Part IV presents reports on four longitudinal research projects in the group care of very young children.

In an epilogue Reginald Lourie, M.D., calls for programs to prevent early distortions in the development of children and for the training of professional and subprofessional workers to recognize the special needs of individual babies and young children. He proposes a network of community centers for children and parents similar to the parent and child centers now being established with support from the Office of Economic Opportunity.

The conferences providing the foundation for the book were convened between April 1964 and October 1965 under the joint sponsorship of the National Institute of Mental Health, the Children's Hospital of Washington, D.C., and American Public Health Association, Maternal and Child Health Section, Committee on Day Care.

DECISION-MAKING IN POVERTY PROGRAMS: case studies from youth-work agencies. Melvin Herman and Michael Munk. Columbia University Press, New York. 1968. 181 pp. $7.50.

Through 20 case studies, the authors here illustrate administrative and operational decision-making in anti-poverty programs serving unemployed, disadvantaged young people. They present five cases under each of the four major heads—planning, operation, organizational change, and research and evaluation. Most sections of the country and large and small cities, suburban towns, and rural areas are represented. The majority of the cases presented were drawn from community youth work programs financed through the Neighborhood Youth Corps, but some are drawn from the Job Corps program. Among the specific problems they deal with are racial imbalance, a high drop-out rate, the supervision of civil service employees stationed in a private agency, and conflicts in service and research demands. Each case includes background material, descriptions, and discussions of the setting of the program, the problem to be solved, the way in which it was approached, and the consequences of the decision.

The 20 cases were selected, collected, and prepared by the Institutes and Curriculum Development Project of the Center for Study of the Unemployed of the Graduate School of Social Work at New York University with support from the Office of Juvenile Delinquency and Youth Development, U.S. Department of Health, Education, and Welfare.

THE CAUSES OF BLINDNESS IN CHILDHOOD. G. R. Fraser and A. I. Friedman. The Johns Hopkins Press, Baltimore. 1968. 245 pp. $12.

This book reports on a study of the causes of blindness in 776 children registered as blind in England and Wales. The study was conducted by the Department of Research Ophthalmology, Royal College of Surgeons, London, for the British Foundation for Research into the Prevention of Blindness. The group represents almost one-fourth of the children registered.

The children in the study were born between 1941 and 1962. Those of school age represented all grade levels, but children who were entirely untrainable because of metal retardation were excluded. Clinical examinations, family histories, medical, school, and social records, and other available information about each child were used to help establish the probable cause of blindness. From such diagnoses, the authors define the roles and relative importance of heredity and environment in childhood blindness.

Each chapter deals with a specific cause of blindness. Chapters are grouped into sections on genetically determined causes, prenatally acquired causes, perinatally acquired causes, and postnatally acquired causes. The authors trace 42 percent of the blindness in the group studied to genetic causes, and 50

percent to environmental causes—6 percent from prenatal causes, 33 percent from perinatal causes, and 11 percent from postnatal causes. Another 8 percent they found due to a complex combination of genetic and environmental factors.

The authors point out the role that premature births have in causing visual handicaps as well as in causing mental retardation, cerebral palsy, and deafness. They predict that acquired blindness in children will "probably" decrease with further advances in perinatal and obstetric care.

The prevention of genetically determined blindness is a long-range goal of research. The authors state that genetic counseling may help to limit propagation of blindness in the future, but individual genetic entities must first be identified to detect asymptomatic carriers.

POPULATION AND PEOPLE. Edward G. Stockwell. Quadrangle Books, Chicago, Ill. 1968. 307 pp. $6.95.

This book seeks to impart to the reader an appreciation and understanding of the close relationship between population trends and many of the political, economic, and social problems of present-day American society and to stimulate the reader to pursue further the study of demographic developments. To this end, the author describes some significant population trends in the United States against the background of a brief discussion of international population trends and provides references for additional reading on each of the topics presented.

The aspects of population the author examines are mortality, fertility, and migration (the basic processes of population change) and population size and growth, composition, and geographic distribution (the major variables in population structure). Within the framework of each of these elements of demography, he directs his discussion toward the underlying determinants and socioeconomic consequences of the trends. More specifically, he considers the relation of population trends to such problems as poverty, race conflict, overpopulation, birth control, and urban congestion and offers some suggestions for possible solutions.

In regard to the United States population composition or structure, the author discusses such characteristics as age, sex, marital status, color, and nativity. He treats the social significance of each of these characteristics, the historical trends leading up to the present situation, and the associated problems.

THE BATTERED CHILD. Edited by Ray E. Helfer and C. Henry Kempe. The University of Chicago Press, Chicago, Ill. 1968. 268 pp. $12.50.

This collection of 11 papers—some original and some previously published in professional journals—discusses the historical, demographic, medical, psychiatric, social, and legal aspects of child abuse. The editors, Ray E. Helfer, M.D., and C. Henry Kempe, M.D., have taken a multidisciplinary approach in presenting information on child abuse which they hope will be used "to change the fate of abused children and their parents."

A psychiatric study of 60 families in which significant abuse has occurred in children under 3 is described by Brandt F. Steele and Carl B. Pollock, University of Colorado psychiatrists. They have found that such parents, many of whom were in their 20's, represent a random cross section of the general population as to education, income, and housing. The authors have observed that the specific pattern of childrearing in parents who abuse their children includes excessive demands for submissive behavior and prompt obedience, constant criticism, and a corresponding parental disregard of the infant's own needs and abilities. These parents had been subject to high expectations, plus a lack of emotional response to their needs—or a lack of "mothering"—in their own childhoods, and subsequently subjected their own children to the same kind of parent-child interaction. Dr. Steele and Dr. Pollock report that in many cases after treatment of the parent, a change in the style of parent-child interaction eliminated the danger of physical harm to the child.

PAID SERVANT. E. R. Braithwaite. McGraw-Hill Book Co., New York. 1968. 219 pp. $4.95.

This first-person account of the experience of a Negro schoolmaster from British Guiana (now Guyana) as a child welfare worker in England with immigrants centers on the author's efforts to find a foster or adoptive home for a 4½-year-old "coloured" boy, Roddy. The child, apparently partly Mexican-American, was rejected by both Negro and white couples as "not one of our kind." This attitude was only one of the obstacles to his efforts. Officials often brought his work to naught, rejecting one couple as not warm enough, delaying so long another couple gave up their request. In the end, he was able to place Roddy with a white family as a foster child to the satisfaction of all.

Between recounting events in Roddy's story, the author describes other cases he handled. Though he was assigned mostly to cases involving "coloured people," he found that his success was seldom due to his color.

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for parents

YOUNG PEOPLE AND CRIME. Arthur H. Cain. The John Day Co., 200 Madison Ave., New York, N.Y. 10036. 1968. 154 pp. $3.95.

HOW TO ADOPT A CHILD. Robert A. Farmer. Arco Publishing Co., 219 Park Ave. South, New York, N.Y. 10003. 1967. 131 pp. $4.95.

THE LAUGHTER AND TEARS OF CHILDREN. Marilyn Bonham. The Macmillan Co., 866 Third Ave., New York, N.Y. 10022. 1967. 213 pp. $4.95.

SPEECH AND LANGUAGE DELAY: a home training program. Second Edition. R. Ray Battin and C. Olaf Haug. Charles C Thomas, 301–327 E. Lawrence Ave., Springfield, Ill. 62703. 1968. 77 pp. $5.50.

A PRIMER FOR PARENTS: a child psychiatrist's advice on raising emotionally healthy children. Jerome S. Fass, M.D. Trident Press, Rockefeller Center, 630 Fifth Ave., New York, N.Y. 10020. 1968. 192 pp. $4.95.

THE RETARDED CHILD: a practical guide to the important recent advances in the care and rehabilitation of the mentally handicapped child. Nancy W. Faber. Crown Publishers, 419 Park Ave. South, New York, N.Y. 10016. 1968. 308 pp. $5.95.

HERE and THERE

Federal legislation

On October 16, President Johnson signed into law the Vocational Education Amendments of 1968. (P.L. 90–576).

The Act reorganizes the entire body of Federal vocational education laws to encourage the upgrading of vocational education programs and gives particular attention to the needs of disadvantaged persons.

The amendments authorize the Commissioner of Education to make *grants to the States for*—

- General *vocational education programs*, arrangements with public and private organizations and institutions to provide vocational training; and related activities such as teacher training and supervision, program evaluation, experimental programs, the development of instructional materials and improvement in administration. No less than 15 percent of the funds made available for such programs are to be used for persons who have academic or economic handicaps; 10 percent for persons otherwise handicapped; 15 percent for persons who have finished or left high school.
- *Educational programs in home economics and consumer education* with special consideration to social and cultural conditions and needs in economically depressed areas.
- *Cooperative work-study vocational education* arrangements designed jointly by school and employer.
- *Work-study programs* which provide part-time employment in public institutions and in private industry for students enrolled full-time in vocational education programs.

The Commissioner is also authorized to make direct grants to institutions of higher education, State Boards of Education, public and private agencies, or local educational agencies (depending on the program) for—

- *Research* in vocational education and related personnel training, experimental programs, demonstration projects, the development of new curricula; and *projects to develop new careers* and occupations in other than professional work in such fields as mental and physical health, crime prevention and correction, welfare, education, municipal services, child care, and recreation.
- *The development and dissemination of curriculum materials.*
- The construction, equipment, and operation of *residential schools of vocational education* for young people between 15 and 21, especially to meet the needs of urban areas with large numbers of school dropouts.
- Cooperative arrangements for the *training or retraining of experienced vocational education educators.*

The Act directs the Commissioner to appoint a National Advisory Council on Vocational Education and requires the States receiving Federal funds for vocational education to establish similar advisory boards.

The Act also directs the Commissioner to study the feasibility of transferring the operation of the Job Corps from the Office of Economic Opportunity to State or joint Federal-State operation; and it directs the President of the United States to make a special study of whether the administration of Project Headstart should be transferred from OEO to another agency of government.

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On October 16, President Johnson also signed into law the Higher Education Amendments of 1968. (P.L. 90–575). This Act amends the various education acts to extend the reach of their programs and to provide for new programs.

Among the new programs it authorizes are Federal assistance to institutions of higher learning for—

- *Cooperative education programs* of alternative full-time study and full-time work.
- *Special services for disadvantaged students* in need of remedial counseling or other services because of deprived backgrounds or other handicaps, such programs to be supported by grants to institutions or groups of institutions.
- *Networks for knowledge* provided by grants to groups of institutions of higher education for developing curricular strengths.
- *Education for public service* including the preparation of graduate or professional students to enter public service, and research in or demonstration of improved methods of education for the public service; to be supported by grants to or contracts with institutions or groups of institutions.
- *Improvement of graduate education* through grants to institutions having doctoral programs for the strengthening of graduate faculties, the acquisition of equipment and the strengthening of administration, such grants to be allocated with a view of regional balance.
- *Law school clinical experience program* consisting of grants to law schools for establishing or expanding programs to provide clinical experience to law students.

The Act transfers the Upward Bound program, to promote post high school education for inadequately prepared disadvantaged students, from the Office of Economic Opportunity to the Office of Education, tying it in with the Talent Search program and the new program of special services for disadvantaged students.

The Act also amends the National Defense Student Loan program to allow forgiveness of 15 percent of a loan for each year the borrower teaches in schools in which 50 percent or more of the children enrolled are from low-income families.

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On September 30, President Johnson signed into law the Handicapped Children's Early Education Assistance Act. This Act authorizes the Commissioner of Education to make arrangements through grants, contracts, or otherwise for *experimental, preschool, and early*

education programs for handicapped children. Such programs are to be designed to facilitate the intellectual, emotional, physical, mental, social, and language development of children; encourage the participation of the children's parents; and acquaint the community with the problems and potentialities of handicapped children.

The term "handicapped children" is defined to mean children who are mentally retarded, hard of hearing, deaf, suffering from speech defects, visually handicapped, seriously disturbed emotionally, or crippled or who because of other health impairments require special education and related services.

Genetic effects of LSD

After studying 66 women of childbearing age who had voluntarily taken the psychedelic drug, LSD, from 1 to 176 times before or during pregnancy and who had exhibited definite genetic damage of the chromosomes, a sociomedical team at George Washington University in Washington, D.C., reported in November that there had been 35 abortions and 25 births of normal-appearing babies in these LSD users during the previous 18 months. Four fetuses that were obtained through therapeutic or spontaneous abortions showed defects of the central nervous system so severe that normal development would have been impossible.

Of the 25 babies, 22 have shown chromosome breakage, the same type of damage found in their mothers. Four have congenital defects not considered serious—hernias, birthmarks, or scars. The babies have been studied at 2 weeks, 6 weeks, 3 months, and then at 3-month intervals.

Most of the young women in the study were from middle-class homes in the suburbs of Washington, D.C. Their ages ranged from 15 to 26. About 80 percent were single, pregnant for the first time, and under 21 years of age. The research team is also following five pregnant girls who have never taken LSD, but whose husbands or boy friends have used the drug.

The long-range consequences of the drug on human reproduction are yet to be proved, but the findings raise the question of possible genetic damage to the children and grandchildren of LSD users—both men and women—according to Cecil B. Jacobson, M.D., geneticist in the George Washington Medical School Department of Obstetrics and Gynecology, who is directing the 2-year study for the Bureau of Drug Abuse and Control of the Department of Justice. His associates are Chesten Berlin, M.D., a pediatrician, and Valerie M. Stubbs, medical sociologist.

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The relation between the use of LSD during pregnancy and fetal damage is being studied under a 2-year research project, recently begun at Stanford Research Institute, Menlo Park, Calif., under a grant from the National Institute of Mental Health. The study, conducted by Edward T. Uyeno, an experimental psychologist, involves injection of five groups of pregnant rats with varying doses of LSD and examination of their offspring for signs of abnormality. The purposes of the project are to help answer the question of whether offspring are deformed physically or neurologically when a pregnant woman takes LSD and—if LSD is found to produce deformities—to determine correlations between dosage and extent of neurological damage.

For the poor

The problems of low-income, innercity families are influencing the current planning, programing, and funding of 150 local voluntary family service agencies, according to a nationwide survey conducted by the Family Service Association of America in the spring of 1968. About 217 agencies responded to a questionnaire sent to the organization's 341 local affiliates. Many of the agencies reported that they are already deeply involved in providing a wide range of services to families in areas of poverty; and 100 reported being encouraged to take this direction by offers from their local United Funds to give priority in fund allocations to innovative programs in the inner city.

Twenty-five additional agencies reported that they were reordering their priorities to meet potentially explosive innercity situations not now regarded as "critical," although their United Funds had not encouraged such efforts. Another 42 agencies, most of them in suburban areas or relatively small cities, reported that they faced no "innercity problems" and they did not plan any changes in their policies or programs.

FSAA's affiliates reported conducting 248 special projects in 1967—the great majority of them in innercity neighborhoods. They fell in three general classifications: participation in the operation of multiservice centers, neighborhood houses, day care centers, and similar facilities; the provision of consultation to sponsoring agencies of innercity programs, such as Headstart, and training nonprofessional staff members and volunteers to work in such projects; and outreach casework service and family life education.

For example, the affiliates have undertaken such projects as the creation of a neighborhood center for residents of a housing project, with emergency help available 24 hours a day, and a training program for low-income persons employed to staff the center; establishment of two "family centers" offering parent education, crisis intervention, and new approaches to service; administration of a cooperative daytime center for young unmarried mothers sponsored by a Board of Education, City Health Department, Visiting Nurses Association, YWCA, and a hospital with funding from the Children's Bureau; location of a permanent office in the ghetto area, with allocation of 30 percent of an agency's total professional hours to this service; and administration and supervision of a Parent and Child Center funded by the Office of Economic Opportunity.

The affiliates participated in 168 projects supported by public funds and 80 projects supported by funds from private foundations and agencies.

Volunteers

During the past 3 years, the Toberman Settlement House in San Pedro, Calif., has developed a volunteer program which in 1967 provided some service from volunteers to nearly half the families assisted by the agency's welfare services division, a casework unit established to help poverty-stricken families with their individual needs. The program is under the direction of Ruth Britton.

Trained and supervised by professional social workers on the agency's staff, the volunteers are supplied by Church Women United in the San Pedro area, other women's organizations, and California State College at Long Beach. They consist of three

kinds: home visitors, transportation providers, and tutors.

After a staff member determines that a family needs special help, a volunteer visitor or tutor, as the occasion warrants, is assigned to it and remains that family's volunteer. The transportation providers, on the other hand, are on call at assigned hours to serve whatever families need help in getting to clinics, agencies, and the like. All volunteers act in a liaison capacity between the family and the agency, notifying the staff of family needs and the family of available services. The home visitors provide the family with emotional support, give evidences that someone cares, and lend a listening ear. Sometimes they accompany a mother to school to discuss a child's problems with his teacher. Sometimes they make suggestions for organizing housework or helping with shopping and meal planning, teach simple sewing, and encourage the mothers to use the resources available for improving their homes—for example, enrolling in a mothers' club or sewing class at the settlement house.

The tutors who include both former teachers and advanced Spanish students at California State College explain class assignments to Spanish-speaking children and help them with their English. They also help other children who are having trouble with school work.

During 1967, a total of 25 volunteers served 190 families through the agency.

Rubella

The first field trials of a rubella vaccine during an actual epidemic of the disease, conducted under the auspices of the U.S. Public Health Service in Taiwan in 1968, show that the vaccine is more than 90 percent effective, according to the director of the field trials, J. Thomas Grayston, M.D., chairman of the University of Washington's Department of Preventive Medicine. The medical team gave a single injection of live attenuated vaccine to each of 3,269 school boys in Taiwan and used about 6,000 more school boys as "controls."

The field trials are part of the current intensive effort by the National Institutes of Health, eight pharmaceutical companies, 12 university medical centers, and four industrial research laboratories to perfect a safe, reliable rubella vaccine to avert the next U.S. epidemic, which is expected in the early 1970's. Activities are being coordinated by the National Institute of Allergy and Infectious Diseases (NIAID) with the Division of Biologics Standards and the National Institute of Neurological Diseases and Stroke also cooperating. Field trials among 10,000 school children in 12 communities in the United States are now under way or have been completed and are being evaluated. The trials involve strains of a live attenuated vaccine (HPV–77) developed by NIH's Division of Biologics Standards in 1966. [CHILDREN, September–October 1966, p. 204.] Other vaccines are also being studied under NIAID-contracted research.

Because it involves a live virus, HPV–77 is not recommended for vaccinating pregnant women who risk severe damage of the fetus if they contract rubella. When research began in 1965, emphasis was placed on developing an inactivated rubella vaccine suitable for administration to pregnant women. Although a number of obstacles—such as inability to achieve high yields of virus in acceptable tissue culture systems and loss of antigenicity during inactivation—have so far prevented development of an effective inactivated vaccine, research is continuing.

The U.S. medical team in Taiwan conducted the field trials of HPV–77 with boys in the first through the fourth grades in two schools in Taipei and two schools in Taichung. In addition to the boys receiving rubella vaccine, 3,010 other boys received an injection of Salk polio vaccine, which does not affect the course of rubella. Other boys in the trials received no vaccine. The study found that if a boy had been exposed to rubella before vaccination, he received no protection. About 50 percent of the unvaccinated children developed rubella during the epidemic.

The length of time for which the rubella vaccine offers protection is not yet known, but will be determined by checking vaccinated children in Taiwan periodically.

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Under a new program designed to meet the needs of deaf-blind children—some 1,250 of whom owe their condition to the rubella epidemic of 1964–65—the Office of Education is supporting the establishment and operation in 1969 of at least eight regional centers to offer comprehensive services to such children and their parents. The centers will be operated by public or nonprofit private organizations and under grants from the Bureau of Education for the Handicapped. Their services will include diagnosis, evaluation, and education of the children and consultation to parents and teachers. The centers may also conduct research and experimentation on new ways to reach deaf-blind children and to help their parents work with them, and may train persons to work in special education programs for the deaf-blind.

The provision of Federal aid for such centers was authorized for 3 years by the 90th Congress in a revision of Title VI of the Elementary and Secondary Education Act (P.L. 90–247) signed by the President in January 1968.

Foster care

For the past 3 years, the Girl Scouts of DuPage County (Ill.) Council and the Wisconsin Department of Health and Social Services, Division of Family Services, have cooperated in providing a camping experience to girls in foster care who have had difficulty in getting along with other children. The project, which began with a 4-day program in a special unit for 12 foster children in 1966, has been expanded to allow foster children to attend as regular campers while continuing the special unit for girls not ready for the regular camp experience.

Most of the girls included in the project have been in foster care in the Eau Claire district of Wisconsin. In 1966, while at camp, they lived in a unit called Cheskamae, they ate their meals with the Girl Scouts, but were provided with a separate camp program designed to help them get along with others. The Girl Scout Council furnished the camp facilities and staff while the State agency furnished consultation from its group worker and the girls' caseworkers and paid for food and equipment through Federal child welfare services funds. The second and third years, the Scout Council set the cost for the girls in the Cheskamae unit at half the normal fee for other campers and the expense was provided for in the regular foster care budget.

For the girls in foster care, the camp experience is designed to offer a chance to improve their ability to get along

with other girls and with adults, to develop interests that will lead to participation in school and community activities, and to have fun. For the foster care caseworkers it is designed to provide information about the girls' behavior with other children and their ability to adjust to new situations gained from firsthand observation; insight into the relations between foster parents and the child; and a chance to recognize latent leadership ability. For the Girl Scouts, it is designed to offer a chance to meet and become friends with girls who had had experiences different from their own.

According to Mary Julia Denton, group work consultant for the Wisconsin Division of Family Services, and Jackie Sanders, executive director of the Girl Scouts of DuPage County Council, the project has achieved these purposes in regard to many of the girls.

Caseworkers have noticed that some girls have adjusted better to their foster homes after they had become friends at the camp with other girls who were also in foster care. As a result of observations made during the camping period, one girl was moved to a new foster home, one girl was adopted ahead of schedule, and another was given psychiatric help.

The girls' stays at the camp were lengthened to 1 week in 1967 and 2 weeks in 1968.

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films on child life

Charges for rental or purchase may be obtained from distributors.

THE ALLEN CASE: A TEACHING FILM. A group of 5-minute films; sound; black and white; purchase.

Demonstrates the process of providing social work service to an AFDC mother with four children separated from her husband at a period of severe stress. The five films show four excerpts from interviews during a 2-month period. They are designed to increase skills of baccalaureate degree social workers in treatment-oriented interviewing. A teaching manual accompanies the film.

Audience: Beginning social workers in public and private social agencies which offer individual services, supervisors, staff development personnel as well as other agencies which offer neighborhood or community services, and schools of social work.

Produced by: The former Bureau of Family Services, now part of the Social and Rehabilitation Service, of the U.S. Department of Health, Education, and Welfare.

Distributed by: Du Art Film Laboratory, Inc., 245 W. 55th St., New York, N.Y. 10019.

L.S.D. TRIP—OR TRAP! 20 minutes; sound; black and white or color; purchase.

Gives information about LSD, from the viewpoint of a 17-year-old boy who does not take the drug although his best friend does.

Audience: Junior and senior high school and college students.

Produced by: Sid Davis Productions.

Distributed by: Sid Davis Productions, 2429 Ocean Park Blvd., Santa Monica, Calif. 90405.

MATERNITY HOSPITAL ROUTINE. 15 minutes; sound; color; preview-before-purchase, purchase, or rent.

Explains the procedures in a hospital maternity ward and labor room and how predelivery tests are made. Depicts the roles of physicians and nurses during delivery, methods of identifying babies, and the care given mothers in the recovery room.

Audience: Expectant parent classes.

Produced by: Moreland-Latchford Films.

Distributed by: Sterling Educational Films, Inc., 241 E. 34th St., New York, N.Y. 10016.

THE POPPE PROJECT: behavior shaping with the severely retarded. 23 minutes; sound; black and white; rent, purchase, or loan for preview-before-purchase.

Documents the progress of eight severely retarded girls, aged 11 to 23, in feeding themselves, dressing, playing, and interacting with each other after being given the concentrated attention of one nurse responsible for stimulation and training.

Audience: Restricted to professional audiences for medical, psychological, or mental health education, training, and research. Nurses, psychologists, physicians, technicians, public health workers, teachers, and others responsible for the direct care of retarded patients.

Produced by: School of Nursing, San Francisco Medical Center, University of California.

Distributed by: Films Sales Distribution, University of California Extension Media Center, 2223 Fulton St., Berkeley, Calif. 94720.

FROM THIS DAY FORWARD. 28½ minutes; sound; black and white; purchase or rent.

Depicts an actual sequence of events in the lives of a young couple and their three small children, the problems they encountered, and their efforts to resolve them; and demonstrates their use of the counseling service of a family service agency in individual, joint, and group interviews. Includes a summary by Margaret Mead.

Audience: Staff members of social agencies; parent education, undergraduate college, and high school classes; and lay groups.

Produced by: KOGO–TV, Time-Life Broadcast, Inc., San Diego, Calif., for the Family Service Association of San Diego.

Distributed by: Association Films, Inc., 600 Madison Ave., New York, N.Y. 10022, and its branch offices.

IN THE JOURNALS

Comprehensive care

Describing the elements of comprehensive health care for children in the October 1968 issue of *Public Health Reports*, Helen M. Wallace, M.D., and four of her associates at the University of California School of Public Health outline the essentials for reaching four objectives of comprehensiveness: optimal care; coordinated care; accessible care; and continuous care. ("Comprehensive Health Care of Children.")

Optimal care, according to the authors, involves attention to medical, dental, social, emotional, educational, vocational, recreational, and nutritional needs, and requires an integrated interdisciplinary team of professional persons and aides. It also requires team planning for the whole family as a unit and attention to the prevention of ill health, through health education of children and parents, family life education, genetic counseling, and family planning services.

Coordinated care, as described by the authors, involves the integration of preventive, curative, and rehabilitative services under a single system of care, and requires relating the program closely to other community services, especially school health services, services for handicapped children, Head-start, and Medicaid.

Accessible care, say the authors, requires providing services close to where the children live, on a 24-hour day, 7-day week basis. Such care, the authors point out, does not necessarily require the provision of all care from the same place at the same times, but it does require the establishment of an effective system of reporting between the providers of service. It also involves home visiting by a public health nurse and elimination of such deterrents to the use of clinic services as impersonal approach, long waiting periods, and requirements for repetitious visits.

Continuous care, the authors point out, means following the child throughout his infancy, childhood, and adolescence whether or not family moves from the original neighborhood of service.

The authors also call attention to the importance of broad community representation in program planning, the integration and improvement of existing community services, the establishment of facilities to fill service gaps, the establishment of record systems to provide for continuity in care, plans to extend services to all in need of them, research to establish the extent of need, and preservice and inservice training of staff.

Parental consent

Exceptions to State laws requiring parental consent to medical treatment of minors are reviewed briefly in the November 1968 issue of the *American Journal of Nursing*, by Nathan Hershey, research professor of health law, University of Pittsburgh School of Public Health. ("Minors and Consent.") Pointing out that traditionally the government is reluctant to intervene in the relationship between parents and children, he maintains that the question of when consent is necessary is often confusing—for example, when parents are not readily accessible to give consent to needed treatment, or when informing the parent does not seem desirable from the point of view of the welfare of the minor.

Some States, the author notes, make exceptions for unmarried pregnant minors, and allow them to consent to their own hospital and medical care without a parent's consent. They also accord parental responsibility to an underage parent, whether married or unmarried, for consent to treatment of their offspring. Married or self-supporting minors in many States are regarded as "emancipated minors" and as such are exempt from the requirement for parental consent, the author reports. He also points out that some States permit physicians to examine and treat a minor for venereal disease with the minor's consent but without consent from or notification of his parents.

The author notes that in recent years some States have passed laws allowing medical procedures to be performed on children in emergencies without parental consent when delay would be damaging. One unresolved question, he says, is whether physicians can be called to account for treating a sick or injured child at the request of adults in whose temporary care the child has been left by his parents. He advises physicians and nurses who face decisions in this regard to consider the interests of the child as of paramount importance.

Musical chairs in AFDC

A number of recent studies have given evidence of a constant "game of musical chairs" among a sizable sector of the poor as families move on and off assistance rolls, using the Federal-State program of aid to families with dependent children as a substitute for income lost from sporadic, marginal employment, according to Genevieve W. Carter writing in the July–August 1968 issue of *Welfare in Review*. ("The Employment Potential of AFDC Mothers.")

The author, chief of intramural research of the Social and Rehabilitation Service, cites studies indicating that families whose applications for AFDC are rejected generally have the same characteristics as those accepted, are "indeed poor, as evidenced by the type of housing, health care, and clothing they have," and differ from the accepted families only in the "degree of disadvantage at the time of application." She reports evidence that among 30 to 50 percent of rejected applicants conditions deteriorate to the point of making them eligible for assistance within 3 to 6 months.

Citing studies that have shown that as many as 80 percent of women in AFDC caseloads have employment histories and that in many states a large proportion of them are working to supplement wages inadequate to meet their families' needs, the author suggests that the majority of mothers in the AFDC program expect and want to work. She names pregnancy, illness, child care problems, and the end of the job as the most frequent reasons for their intermittent episodes of dependency, which, she says,

will continue to occur as long as the job opportunities open to these mothers are a part of the irregular economy.

Raising a number of questions pertinent to policy development—such as whether young mothers susceptible to acute child care problems but with more training potential should be given preference in training programs over older mothers, and whether mothers with marginal income who are not receiving assistance should be excluded from the training and child care opportunities being planned—she suggests that before research can be helpful in decision-making, the goals of policy must be clear. And she asks: "Are the objectives to instill work ethics in the AFDC family, to contribute to the economy, to increase family income, or to offer a choice to the mother who is the family head?"

Living on AFDC

The results of a study to determine how well families are living who receive assistance under New Mexico's Federally aided program of aid to families with dependent children (AFDC) are reported in the October 1968 issue of the quarterly *Social Work*. ("By Bread Alone, and Little Bread: Life on AFDC," by Gil Bonem and Philip Reno.) The authors, research associates in the Department of Economics, University of New Mexico, derived their findings from interviews about family expenditures conducted in April 1967 with 33 mothers in the AFDC program and from "secondary sources," including a report of the Bureau of Labor Statistics, U.S. Department of Labor, on average consumer expenditures and income for the Western United States for 1960–61.

Their findings showed that while over 45 percent of the expenditures of the AFDC families went for food as against 24 percent for the average Western family, the average per capita expenditure for food in the AFDC families was $234 per year (including the value of surplus commodities) as against the average per capita expenditure for food among Western families of $417 per year. The $4.50 per person average weekly food expenditure in the AFDC families was 10 percent below the per capita expenditure in the Department of Agriculture's economy food plan for adequate nutrition, adjusted for 1967 prices.

While the budgets on which the AFDC monthly payments were based (before a 5 percent reduction of the total amount budgeted) included an average of $53 for rent at the time of the interviews, the AFDC families were actually paying an average of $67 for rent, thus cutting into the amounts budgeted for other needs. Their expenditures for clothing averaged $27 per person a year; their average family expenditure for durable consumer goods was $44 a year as against $400 per family in the country as a whole in 1962.

The authors report that the families on AFDC spent "a barely discernible amount" for recreation, personal care, and "other such pleasures that people find in life." Maintaining that "the gap between 'modest but adequate living' and AFDC living" is widening, the authors point out that the AFDC payment in New Mexico decreased from $32.37 per person in 1960–61 to $30.67 in December 1967 in spite of sharp increases in living costs.

READERS' EXCHANGE

HERZOG AND SUDIA: *Implications for programs*

"Fatherless Homes—A Review of Research" by Elizabeth Herzog and Cecelia E. Sudia, which discusses the research on the effects on children of growing up in fatherless homes, is a timely and significant article [CHILDREN, September–October 1968].

The fatherless home has become a national and community issue as new strategies and programs have been devised for strengthening families and individuals in our inner cities and depressed rural areas.

The day-to-day experience of social workers, educators, and others has seemed to support the classic view about the deleterious effects of growing up in a fatherless home. However, as the authors point out, the emphasis on the single causative factor—the absence of the father—has led to broad generalizations, reinforced, untested assumptions, and the acceptance of new stereotypes, which deflect our efforts to meet the needs of children. My own experience in the child welfare field confirms the validity of the authors' emphasis on the need to consider a cluster of variables, in assessing the effects on children of growing up in a fatherless home.

As the authors imply, there does not appear to be any basis for concluding that fatherless homes *per se* have an adverse decisive effect on the development of children. Therefore, it is now imperative to reassess and modify the practice, theory, policies, and programs in the health, welfare, and educational fields that have been derived from this assumption.

The authors place proper emphasis on the failure of research workers to point out the other side of the coin: that the large proportion of children who grow up in fatherless homes do *not* show adverse effects; and that two-thirds of the children in poverty-stricken populations are growing up in two-parent homes, including many who show the same developmental and behavioral problems as children in fatherless homes. It seems to me that research efforts might be more fruitfully directed toward identifying family strengths, coping patterns, and the areas where children need additional supports.

My experience also confirms the importance of defining the social and com-

munity context in which family patterns develop and are maintained. Male unemployment and low-paying employment have tended to impinge negatively on the role performance of inner-city fathers and to weaken family life.

I have been concerned about the extent to which professional and community values impose negative sanctions upon fatherless families. For example, children must often admit to fatherlessness for institutional records; and for some community activities a child's participation is tied to the presence of the father. In contrast, the Scandinavian countries recognize the one-parent family and provide a healthy environment for the development of children through a broad, integrated system of social supports.

It is my earnest hope that administrators and practitioners will be led by this review of research to reassessment and change so that the programs will effectively supplement the mothers' efforts in one-parent families to meet their children's developmental needs.

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For fatherless boys

Although it has provided stimulating reading, the article on fatherless homes by Herzog and Sudia omitted a significant aspect of treatment intervention when they imply that recognition is not given to the single-parent family "as a family form in its own right." I refer to the Big Brother agencies.

A Big Brother program is a basic child welfare service geared to strengthening the lives of children. Its help to the fatherless boy who lives at home is unique in recognizing that the child's problem may be connected to the lack of an adult male figure in the house. Mothers who request the service of a volunteer Big Brother attempt to fill a void in their son's lives.

Because there are one-parent families that experience parent-child problems requiring professional intervention, we have geared our program to help fatherless families through a combination of social work and volunteer services, in the following ways:

- To help the mother achieve a more realistic understanding of herself as a person, her parental role, and what she can expect from an adult male volunteer to provide the child in the way of friendship—identifying with maleness, exposure to vocational interests, and experiencing various methods of relating through observation of the Big Brother.
- To help the mother reevaluate her goals, not only as a parent, but as a wage earner, a person with self-interests, a member of the community.
- To help the fatherless boy gain self-confidence and confidence in another human being who cares about him.
- To help the fatherless boy attain the responsibility and reliability that is needed to develop closer ties with other children.
- To help all the children in a fatherless family achieve increased understanding of each other's needs and more positive parent-children relationships.

Thus, the Big Brother agencies in the United States and Canada are providing experience for helping the single-parent family function as a "family form" in itself.

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MOSS: *Some broader implications*

I wish to comment on the process for family interviews in preplacement planning and postplacement service to children placed voluntarily in institutions as described by Sidney Z. Moss in CHILDREN, November–December 1968. ["Integration of the Family into the Child Placement Process."] His position can be heartily endorsed at a time when caseworkers still operate on the one-to-one interview with the mistaken idea they are protecting the troubled child from the harshness of placement realities.

Mr. Moss says the word "institution" could be replaced with "foster home." We could also substitute for the phrase "voluntary placement" the phrase "involuntary or court-ordered placement," the type of placement so well known to the public agency working in the area of protective services. The use of the family interview with participation by the child prior to and at the time of the court hearing and of the resulting foster home placement could accomplish the same kind of family mobilization Mr. Moss describes in relation to voluntary institutional placement. The fact of custody should not stand in the way of our continuously reaching out to parents involuntarily deprived of their children.

The article outlines good practice in family-centered postplacement interviews. This concept of integrated service needs translation for the caseworker faced with postplacement service to parents, child, and foster parents when the child in the agency's custody has been placed in a foster home. Historically we have fragmented the postplacement process through separate interviews with parents, foster parents, and the child.

The purpose of postplacement service could be better served by joint interviews with all parties involved in the very complex parent-child-foster parent-caseworker constellation. Such interviews are sometimes arranged to assess progress, redefine goals, and plan for the future. If they were scheduled regularly and purposefully rather than at times of crisis with some vague idea of "getting everybody together," we might effectively and sensitively accomplish the reuniting of child and family. We could in this way come sooner to realistic decisions about permanent arrangements for the child away from his parents if this appeared to be the plan of choice.

We must acknowledge intricacies of family interviews for the caseworker who is accustomed to "taking Joe out for a coke." The worker could find the integrated family interview a three-ring circus unless he is provided inservice training and supervision specifically directed toward group interview techniques.

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HEW refers to Department of Health, Education, and Welfare; SRS, to Social and Rehabilitation Service; PHS, to Public Health Service.

SELECTING AUTOMOBILE SAFETY RESTRAINTS FOR SMALL CHILDREN. HEW, PHS, National Center for Urban and Industrial Health. PHS Publicaton No. 1783. 1968. 5 pp. Single copies free from NCUIH, Injury Control Program, 222 East Central Parkway, Cincinnati, Ohio 45202.

Gives information on selecting automobile safety devices including safety seats and harnesses for children.

HELPING YOUTH: a study of six community organization programs. Charles F. Grosser. HEW, SRS, Office of Juvenile Delinquency and Youth Development. JD Publication No. 1006. 1968. 72 pp. 35 cents.

Reports on a study of community action programs to deal with underlying causes of juvenile delinquency in two areas of New York City; Syracuse, N.Y.; Washington, D.C.; Houston, Tex.; and Charleston, W. Va.

MENTAL RETARDATION ACTIVITIES OF THE U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE. HEW, Office of the Secretary, Secretary's Committee on Mental Retardation. January 1968. 107 pp. 65 cents.

Summarizes 1967 legislation affecting mental retardation programs in the Department and describes current programs for the mentally retarded administered by the Department's constituent agencies.

CHILD WELFARE TRAINING GRANT AWARDS: fiscal year 1968. HEW, SRS, Children's Bureau. 1968. 11 pp. Single copies free from the Bureau.

Annual summary of Federal child welfare teaching grants including traineeships and grants for short-term training.

ANALYZING DELINQUENT BEHAVIOR: a new approach. John M. Martin, Joseph P. Fitzpatrick, and Robert E. Gould, M.D. HEW, SRS, Office of Juvenile Delinquency and Youth Development. 1968. 20 pp. 20 cents.

Outlines methods for case and neighborhood assessment in the study and understanding of delinquent behavior, developed by a team cosponsored by Fordham University and New York University.

THE WEBSTER SCHOOL: a District of Columbia program for pregnant girls. HEW, SRS, Children's Bureau. CB Research Report No. 2. 1968. 93 pp. 55 cents.

Describes and evaluates a continuing comprehensive program for pregnant adolescent girls as conducted in Washington, D.C., from 1963 to 1966; and summarizes 35 comprehensive programs for young unmarried mothers in other cities.

PROBLEMS AND PROGRESS IN ADOPTION. Ursula M. Gallagher. HEW, SRS, Children's Bureau, 1968. 8 pp. Single copies free from the Bureau.

Discusses recent trends in adoption of hard-to-place children and some deterrents to adoption.

THINKING ABOUT DRINKING. HEW, PHS, National Institute of Mental Health, and SRS, Children's Bureau. PHS Publication No. 1668. CB Publication No. 456. 1968. 31 pp. 20 cents.

Prepared as a basis for discussions about drinking by young people, this booklet presents facts about alcohol and its effects and offers suggestions for behavior related to drinking for those who abstain and for those who choose to drink. Includes a discussion guide.

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